SERFF Tracking Number:	*CMPL-125649032*	*State:*	*Arkansas*
Filing Company:	*Health Care Service Corporation*	*State Tracking Number:*	*39016*
Company Tracking Number:	*HCSC ET BCBSTX*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*HCSC ET BCBSTX*		
Project Name/Number:	*HCSC ET BCBSTX/HCSC ET BCBSTX*		

Filing at a Glance

Company: Health Care Service Corporation

Product Name: HCSC ET BCBSTX	SERFF Tr Num: CMPL-125649032	State: ArkansasLH
TOI: H16G Group Health - Major Medical	SERFF Status: Closed	State Tr Num: 39016
Sub-TOI: H16G.001A Any Size Group - PPO	Co Tr Num: HCSC ET BCBSTX	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Nancy French	Disposition Date: 06/03/2008
	Date Submitted: 05/15/2008	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: HCSC ET BCBSTX	Status of Filing in Domicile:
Project Number: HCSC ET BCBSTX	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer
Filing Status Changed: 06/03/2008	
State Status Changed: 06/03/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Dear Commissioner:

Compliance Research Services is pleased to submit the enclosed forms on behalf of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). A letter of filing authorization is enclosed.

HCSC does business in various states as follows:

• Blue Cross and Blue Shield of Illinois in Illinois;

SERFF Tracking Number:	*CMPL-125649032*	*State:*	*Arkansas*
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Project Name/Number:	*HCSC ET BCBSTX/HCSC ET BCBSTX*		

• Blue Cross and Blue Shield of Texas in Texas;
• Blue Cross and Blue Shield of Oklahoma in Oklahoma; and
• Blue Cross and Blue Shield of New Mexico in New Mexico.

HCSC provides group medical insurance to Texas employers that have employees located in many states. This filing is for HCSC's Texas division however, we will be submitting similar filings for the other divisions of the company.

We are also sending hard copies of these forms to you by mail as you requested in November of 2007.

Note that the Arkansas Rider, Form ETGB-AR-HCSC-07 was submitted and is currently being reviewed under SERFF Tracking number CMPL-125619854. The rider will be used with the Certificate submitted with that filing as well as the above noted Certificate.

Submitted Materials. The coverage in question is true group coverage sold in Texas by licensed Texas agents and brokers.

The provisions of the certificate may change according to the benefits negotiated between the employer and HCSC. The enclosed certificate includes provisions for participating provider hospitals and physicians. Coverage may also be issued on a fee for service basis without the network provisions. Individuals insured under network plans have access to their local Blue Cross provider networks under the national Blue Cross association BlueCard plan. The rider has been drafted to bring the certificate into compliance with applicable Arkansas requirements.

Provisions in the certificate that may vary from employer to employer are bracketed. HCSC requests the right to change the type style and paper size or to issue the forms in electronic format.

The forms have been tested for readability. Certification of readability is enclosed.

If you have any questions or comments, please call me at 513-894-6050 or by email at dsimon@crssolutionsgroup.com.

Thank you for your assistance in this matter.

SERFF Tracking Number:	*CMPL-125649032*	*State:*	*Arkansas*
Filing Company:	*Health Care Service Corporation*	*State Tracking Number:*	*39016*
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Product Name:	*HCSC ET BCBSTX*		
Project Name/Number:	*HCSC ET BCBSTX/HCSC ET BCBSTX*		

Sincerely,

J. David Simon, CLU
President
Phone: 513.984.6050
Fax: 513.984.7212
E-Mail Address: dsimon@crssolutionsgroup.com

Company and Contact

Filing Contact Information

(This filing was made by a third party - complianceresearchservicesllc)

Nancy French, Product Manager
10921 Reed Hartman Highway
Cincinnati, OH 45242
nfrench@crssolutionsgroup.com
(513) 984-6050 [Phone]
(513) 984-7212[FAX]

Filing Company Information

Health Care Service Corporation
300 East Randolph Street
Chicago, IL 60601
(513) 984-6050 ext. [Phone]

CoCode: 70670
Group Code: 917
Group Name:
FEIN Number: 36-1236610

State of Domicile: Illinois
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	

SERFF Tracking Number:	*CMPL-125649032*	*State:*	*Arkansas*
Filing Company:	*Health Care Service Corporation*	*State Tracking Number:*	*39016*
Company Tracking Number:	*HCSC ET BCBSTX*		
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Product Name:	*HCSC ET BCBSTX*		
Project Name/Number:	*HCSC ET BCBSTX/HCSC ET BCBSTX*		

Per Company: No

SERFF Tracking Number:	*CMPL-125649032*	*State:*	*Arkansas*
Filing Company:	*Health Care Service Corporation*	*State Tracking Number:*	*39016*
Company Tracking Number:	*HCSC ET BCBSTX*		
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Product Name:	*HCSC ET BCBSTX*		
Project Name/Number:	*HCSC ET BCBSTX/HCSC ET BCBSTX*		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Health Care Service Corporation	$50.00	05/15/2008	20344140

SERFF Tracking Number:	*CMPL-125649032*	*State:*	*Arkansas*
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Project Name/Number:	*HCSC ET BCBSTX/HCSC ET BCBSTX*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/03/2008	06/03/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	05/16/2008	05/16/2008	Nancy French	05/27/2008	05/27/2008

SERFF Tracking Number:	*CMPL-125649032*	*State:*	*Arkansas*
Filing Company:	*Health Care Service Corporation*	*State Tracking Number:*	*39016*
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Product Name:	*HCSC ET BCBSTX*		
Project Name/Number:	*HCSC ET BCBSTX/HCSC ET BCBSTX*		

Disposition

Disposition Date: 06/03/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CMPL-125649032*	*State:*	*Arkansas*
Filing Company:	*Health Care Service Corporation*	*State Tracking Number:*	*39016*
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Product Name:	*HCSC ET BCBSTX*		
Project Name/Number:	*HCSC ET BCBSTX/HCSC ET BCBSTX*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Readability	Approved-Closed	Yes
Supporting Document	Authorization	Approved-Closed	Yes
Supporting Document	5-27-2008 Certification	Approved-Closed	Yes
Form	Certificate	Approved-Closed	Yes
Form *(revised)*	Rider	Approved-Closed	Yes
Form	Rider	Withdrawn	No

SERFF Tracking Number:	*CMPL-125649032*	*State:*	*Arkansas*
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Product Name:	*HCSC ET BCBSTX*		
Project Name/Number:	*HCSC ET BCBSTX/HCSC ET BCBSTX*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/16/2008
Submitted Date	05/16/2008
Respond By Date	

Dear Nancy French,

This will acknowledge receipt of the captioned filing.

Objection 1

- Rider (Form)

Comment: The rider for Arkansas residents should include the following:

1. There should be a conversion privilege that complies with ACA 23-86-115.
2. Please add to the list of providers a Nurse Anesthetists as required by ACA 23-79-114(f).
3. It is requested that you certify that benefits payable a PPO and Non-PPO will comply with our Bulletin 9-85. There can be no more than a 25% differential in payment of benefits between a PPO and Non-PPO.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	05/27/2008
Submitted Date	05/27/2008

Dear Rosalind Minor,

Comments:

Response 1

Comments: Dear Ms. Minor:

The following is in response to your May 15, 2008 objection:

SERFF Tracking Number:	*CMPL-125649032*	*State:*	*Arkansas*
Filing Company:	*Health Care Service Corporation*	*State Tracking Number:*	*39016*
Company Tracking Number:	*HCSC ET BCBSTX*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*HCSC ET BCBSTX*		
Project Name/Number:	*HCSC ET BCBSTX/HCSC ET BCBSTX*		

1. The Conversion provision has been added to the Rider where it has been revised to remove the requirement that the insured be covered for at least 3 months under the Group policy in order to convert coverage, to comply with ACA 23-86-115. Additionally, the provision has been reworded slightly to be consistent with other terminology in the Certificate.

2. The provision shown in the Rider addressing Providers has been revised to add Nurse Anesthetists as required by ACA 23-79-114(f).

3. Enclosed is certification that there will be no more than a 25% differential in payment of benefits between a PPO and NON-PPO provider.

If you have any questions or comments, please call me at 513-894-6050 or by email at dsimon@crssolutionsgroup.com.

Thank you for your assistance in this matter.

Related Objection 1

Applies To:

- Rider (Form)

Comment:

The rider for Arkansas residents should include the following:

1. There should be a conversion privilege that complies with ACA 23-86-115.
2. Please add to the list of providers a Nurse Anesthetists as required by ACA 23-79-114(f).
3. It is requested that you certify that benefits payable a PPO and Non-PPO will comply with our Bulletin 9-85. There can be no more than a 25% differential in payment of benefits between a PPO and Non-PPO.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: 5-27-2008 Certification

Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific	Readability Score	Attach Document

SERFF Tracking Number:	*CMPL-125649032*	*State:*	*Arkansas*
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Project Name/Number:	*HCSC ET BCBSTX/HCSC ET BCBSTX*		

			Data		
Rider	ETGB-AR-HCSC–07	Certificate Amendment, Initial Insert Page, Endorsement or Rider		40	HCSC Arkansas ET Rider_rev 051608.pdf
Previous Version					
Rider	*ETGB-AR-HCSC–07*	*Certificate Amendment, Initial Insert Page, Endorsement or Rider*		*40*	HCSC Arkansas ET Rider_rev 080907.pdf

SERFF Tracking Number:	*CMPL-125649032*	*State:*	*Arkansas*
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No Rate/Rule Schedule items changed.

Sincerely,
Nancy French

SERFF Tracking Number:	*CMPL-125649032*	*State:*	*Arkansas*
Filing Company:	*Health Care Service Corporation*	*State Tracking Number:*	*39016*
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Product Name:	*HCSC ET BCBSTX*		
Project Name/Number:	*HCSC ET BCBSTX/HCSC ET BCBSTX*		

Form Schedule

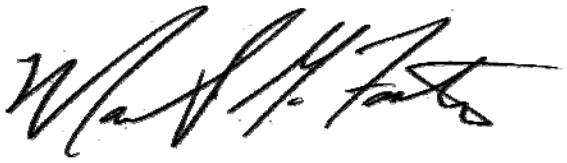
Lead Form Number: COC-CB-LG-0707

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	COC-CB-LG-0707	Certificate	Certificate	Initial		42	Texas BCBS Master Certificate.pdf
Approved-Closed	ETGB-AR-HCSC–07	Certificate Amendment, Insert Page, Endorsement or Rider	Rider	Initial		40	HCSC Arkansas ET Rider_rev051608.pdf

CERTIFICATE OF COVERAGE

Blue Cross and Blue Shield of Texas
(herein called "BCBSTX" or "Carrier")

Hereby certifies that it has issued a Group **[Managed Health Care], [Traditional Medical Benefits],** [and] **[Prescription Drug Program]** Contract (herein called the "Plan") for the Employees of the Employer named on the Contract. Subject to the provisions of the Plan, each Employee (Subscriber) to whom a Blue Cross and Blue Shield Identification Card is issued, together with his eligible Dependents for whom application is initially made and accepted, shall have coverage under the Plan, beginning on the Effective Date shown on the Identification Card, if the Employer makes timely payment of total premium due to the Carrier. Issuance of this Benefit Booklet by BCBSTX does not waive the eligibility and Effective Date provisions stated in the Plan.



[_____]
[President of Blue Cross and Blue Shield of Texas]

The Schedule of Coverage enclosed with this Benefit Booklet indicates benefit percentages, [Prescription Drug Deductibles,] [Copayment Amounts], [maximums], and other benefit and payment issues that apply to the Plan.

The Schedule of Coverage specifies benefits for your:

Prescription Drug Program coverage

NOTICE OF SEPARATE AVAILABLE COVERAGE

This notice is required by Texas legislation to be provided to you. It is to inform you, the Employee, that your Employer has selected this health benefit coverage. BCBSTX does not offer a rider or separate insurance contract through your Employer that would provide coverage in addition to the coverage under this Contract.

THE INSURANCE CONTRACT UNDER WHICH THIS BENEFIT BOOKLET IS ISSUED IS NOT A CONTRACT OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

IMPORTANT NOTICE

To obtain information or make a complaint:

- You may call Blue Cross and Blue Shield of Texas's toll-free telephone number for information or to make a complaint at:

  1-800-521-2227

- You may also write to Blue Cross and Blue Shield of Texas at:

  P. O. Box 660044
  Dallas, Texas 75266-0044

- You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

  1-800-252-3439

- You may write the Texas Department of Insurance at:

  P. O. Box 149104
  Austin, Texas 78714-9104
  Fax: (512) 475-1771
  Web: http://www.tdi.state.tx.us
  E-mail: ConsumerProtection@tdi.state.tx.us

- **PREMIUM OR CLAIM DISPUTES:** Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

- **ATTACH THIS NOTICE TO YOUR POLICY:** This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

- Usted puede llamar al numero de telefono gratis de Blue Cross and Blue Shield of Texas's para informacion o para someter una queja al:

  1-800-521-2227

- Usted tambien puede escribir a Blue Cross and Blue Shield of Texas al:

  P. O. Box 660044
  Dallas, Texas 75266-0044

- Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al :

  1-800-252-3439

- Puede escribir al Departmento de Seguros de Texas:

  P. O. Box 149104
  Austin, Texas 78714-9104
  Fax: (512) 475-1771
  Web: http://www.tdi.state.tx.us
  E-mail: ConsumerProtection@tdi.state.tx.us

- **DISPUTAS SOBRE PRIMAS O RECLAMOS:** Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

- **UNA ESTE AVISO A SU POLIZA:** Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

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SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
[Waiting Period	[0] [30] [60] [90] [120] [365] days [other as elected by the large group employer] [Administered in accordance with the Employer's group health plan]]	
[Deductibles] • **[Upfront Deductible]** *[Combined In-Network and Out-of-Network]* *[Applies to all Eligible Expenses]* • **[Calendar Year Deductible]** [*Combined In-Network and Out-of Network]* *[Applies to all Eligible Expenses]*	[[$XX – per individual] [$XX – per family]] [[$XX – per individual] [$XX – per family]]	
[Deductibles] • [Per-admission Deductible] • [Calendar Year Deductible] [*Three-month Deductible carryover applies]* *[Applies to all Eligible Expenses]* • [Prescription Drug Deductible]	[$XX per-admission Deductible] [$XXX] – [per individual] [per Employee only coverage] [$XXX] – [per family] [per Family coverage] [$XXX – per individual]	[$XX per-admission Deductible] [$XXX] – [per individual] [per Employee only coverage] [$XXX – per family] [per Family coverage] [$XXX – per individual]]
[Coinsurance Stop-Loss Amounts] **[Out-of-Pocket Maximum]** [Combined In and Out-of Network]	[$XX – per individual] [$XX – per family]	
[Coinsurance Stop-Loss Amounts] **[Out-of-Pocket Maximum]**	[$XXXX – per individual] [$XXXX – per family]	[$XXXX – per individual] [$XXXX – per family]
[Out-of-Pocket Maximum]	[$XXX – per Employee only coverage] [$XXX per Family coverage]	[$XXX – per Employee only coverage] [$XXX per Family coverage]
[Copayment Amount Required]		
• [Physician office visit/consultation] • [Surgical procedures performed in the Physician's office] • [Allergy injections when billed separately from an office visit] • [Outpatient Hospital emergency room visit] • [Urgent Care center visit] • [Physical Medicine Services]	[$XX Copayment Amount] [$XX Copayment Amount] [$XX Copayment Amount] [$XX outpatient Hospital emergency room visit Copayment Amount] [$XX Copayment Amount] [$XX Copayment Amount]	[$XX outpatient Hospital emergency room visit Copayment Amount]

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
[Annual Maximum Benefits per Participant]	[$XXXXXX]	
Maximum Lifetime Benefits per Participant	[$XXXXXX]	
Inpatient Hospital Expenses [All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.]	[Upfront Deductible then] XX% of Allowable Amount [after $XXX per-admission Deductible] [after Calendar Year Deductible] [No penalty for failure to preauthorize services]	[Upfront Deductible then] XX% of Allowable Amount [after $XXX per-admission Deductible] [after Calendar Year] Deductible] [$XXX penalty for failure to preauthorize services]
Medical-Surgical Expenses		
• [Physician office visit/consultation][Physician office visit/ consultation, including lab and x-ray]	[Upfront Deductible then] [XX% of Allowable Amount [after $XX Copayment Amount]]	[Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]]
• [Lab & X-ray in other outpatient facilities, [excluding Certain Diagnostic Procedures]]	[Upfront Deductible then] [XX% of Allowable Amount after [$XX Copayment Amount] [Calendar Year Deductible]]	[Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]]
• [Surgical procedures performed in the Physician's office]	[Upfront Deductible then] [XX% of Allowable Amount [after $XX Copayment Amount]]	[Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]]
• [Inpatient visits and Certain Diagnostic Procedures]	[Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]]	[Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]]
• [Home Infusion Therapy]	[Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]]	[Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]]
• [Physician surgical services performed in setting other than [the Physician's office] [or] [an outpatient facility] [or] [any setting]	[Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]]	[Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]]
• [In-Vitro Fertilization Services]	[Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]]	[Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]]
• [Smoking Cessation] [[$XXXX] Lifetime Maximum Smoking Cessation Benefit per Participant applies] [[$XXXX] Annual Maximum Smoking Cessation Benefit per Participant per Calendar Year applies]	[Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]]	[Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]]

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
• Durable Medical Equipment (DME) [$XXXX] Calendar Year Maximum benefit per Participant]	[Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]]	[Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]]
Extended Care Expenses [Calendar Year Deductible [applies] [does not apply]]		
▪ [Skilled Nursing Facility] [[$XXXXXX] Calendar Year maximum] [[XX] days per Calendar Year]	[Upfront Deductible then] [XX% of Allowable Amount] [after Calendar Year Deductible]	[Upfront Deductible then] [XX% of Allowable Amount] [after Calendar Year Deductible]
▪ [Home Health Care] [[$XXXXX] Calendar Year maximum] [[60] visits]	[Upfront Deductible then] [XX% of Allowable Amount] [after Calendar Year Deductible]	[Upfront Deductible then] [XX% of Allowable Amount] [after Calendar Year Deductible]
▪ [Hospice Care] [[$XXXXX] lifetime maximum] [[XX] days Lifetime Maximum]	[Upfront Deductible then] [XX% of Allowable Amount] [after Calendar Year Deductible]	[Upfront Deductible then] [XX% of Allowable Amount] [after Calendar Year Deductible]
[Treatment of Chemical Dependency Three separate series of treatments for each covered individual	Covered same as any other sickness	Covered same as any other sickness**]**
[Serious Mental Illness **Inpatient Services** Hospital services (facility)	[Upfront Deductible then] XX% of Allowable Amount [after per-admission Deductible] [after Calendar Year Deductible]	[Upfront Deductible then] XX% of Allowable Amount[after per-admission Deductible] [after Calendar Year Deductible]
Physician services [Limited to 45 inpatient days/inpatient visits each Calendar Year]	[Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible]	[Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible]
Outpatient Services Physician expenses (office setting)	[Upfront Deductible then] XX% of Allowable Amount [after $XX Copayment Amount] [after Calendar Year Deductible]	[Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible]
Other Outpatient Services [Limited to 60 visits each Calendar Year]	[Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible]	[Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible]**]**
[Serious Mental Illness Benefits for Public Entity	[Same as any other physical illness]	[Same as any other physical illness] **]**

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
[Serious Mental Illness	[Benefits determined on the same basis as for Mental Health Care]	[Benefits determined on the same basis as for Mental Health Care] **]**
[Mental Health Care **Inpatient Services** Hospital services (facility) Physician services [Limited to [30] inpatient days/inpatient visits each Calendar Year] **Outpatient Services** Physician expenses (office setting) Other Outpatient Services [Limited to [30] visits each Calendar Year]	[Upfront Deductible then] XX% of Allowable Amount [after per-admission Deductible] [after Calendar Year Deductible] [Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible] [Upfront Deductible then] [XX% of Allowable Amount [after $XX Copayment Amount] [after Calendar Year Deductible]] [Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible]	[Upfront Deductible then] XX% of Allowable Amount [after per-admission Deductible] [after Calendar Year Deductible] [Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible] [Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible] [Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible] **]**
[Mental Health Care **Inpatient Services** Hospital services (facility) Physician services **Outpatient Services** Physician expenses (office setting) Other Outpatient Services **[Includes treatment for Serious Mental Illness]** **[$XXXX][Calendar Year maximum benefit]** **[$XXXXX] [lifetime maximum benefit]**	[Upfront Deductible then] XX% of Allowable Amount [after per-admission Deductible] [after Calendar Year Deductible] [Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible] [Upfront Deductible then] XX% of Allowable Amount [after $XX Copayment Amount] [after Calendar Year Deductible] [Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible]	[Upfront Deductible then] XX% of Allowable Amount [after [per-admission Deductible] [after Calendar Year Deductible] [Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible] [Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible] [Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible] **]**

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Emergency Room Treatment Accidental Injury & Emergency Care within first 48 hours • Facility Charges • Physician Charges	[Upfront Deductible then] XX% of Allowable Amount [after $XX outpatient Hospital emergency room Copayment Amount [waived if admitted] [after Calendar Year Deductible]] [Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible]	
[Emergency Room Treatment Non-Emergency Care • Facility Charges • Physician Charges]	[Upfront Deductible then] [XX% of Allowable Amount after [$XX outpatient Hospital emergency room Copayment Amount [waived if admitted]] [Calendar Year Deductible]] [Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]]	[Upfront Deductible then] [XX% of Allowable Amount after [$XX outpatient Hospital emergency room Copayment Amount [waived if admitted]]] [Calendar Year Deductible] [Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]]
[Urgent Care Services] • [Urgent Care center visit] [Urgent Care center visit – including lab & x-ray (excluding Certain Diagnostic Procedures)] • [Services received during an Urgent Care visit - including Lab & x-ray [excluding Certain Diagnostic Procedures]]	[Upfront Deductible then] [XX% of Allowable Amount after [$XX Copayment Amount] [Calendar Year Deductible]] [Upfront Deductible then] [XX% of Allowable Amount after [$XX Copayment Amount] [Calendar Year Deductible]]	[Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]]
Ground and Air Ambulance Services	[Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible]	

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
[Preventive Care Office visit for routine physical examinations, well baby care, [immunizations for Participants 6 years & over,] [routine lab and x-ray,] [vision exams,] [and] hearing exams [$XX maximum benefit amount per Participant per [XX-month] period] [Immunizations for Dependent children through the date of the child's 6th birthday] [Immunizations for Dependent children age 7 and under]	[Upfront Deductible then] XX% of Allowable Amount [after $XX Copayment Amount for Physician office visit] [after Calendar Year Deductible] [Deductible waived] [100%] [Deductible waived]	[Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible] [Deductible waived] [100%] [Deductible waived] **]**
[Preventive Care Office visits for routine physical examinations, well baby care, [vision exams] [and hearing exams] Office services, [immunizations for Participants after 6th birthdate] [lab and x-ray,] [and hearing tests] [$XX maximum benefit amount per Participant per [XX-month] period] [Immunizations for Dependent children through the date of the child's 6th birthday] [Immunizations for Dependent children age 7 and under]	[Upfront Deductible then] XX% of Allowable Amount [after $XX Copayment Amount for Physician Office Visit] [after Calendar Year Deductible] [Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible] 100% [Deductible waived]	[Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible] [Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]] 100% [Deductible waived] **]**
Speech and Hearing Services, including hearing aids [$XXXX] maximum benefit amount each [XX-Month] period for hearing aids]	[Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible]	[Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible]
Physical Medicine Services [$XXXX] Calendar Year Maximum benefit per Participant] [XX] visits per Participant each Calendar Year]	[Upfront Deductible then] XX% of Allowable Amount [after $XX Copayment Amount] [after Calendar Year Deductible]	[Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible]

SCHEDULE OF COVERAGE

Plan Provisions	Traditional Medical Benefits
[Waiting Period	[[0] [30] [60] [90] [120] [365] days] [Administered in accordance with the Employer's group health plan]]
[Deductibles] • [Upfront Deductible] [*Applies to all Eligible Expenses*] • [Per-Admission Deductible] • [Calendar Year Deductible] [*Three month Deductible carryover applies*] [*Applies to all Eligible Expenses*] • [Prescription Drug Deductible]	[[$XX – per individual] [$XX – per family]] [No per-admission Deductible] [$XXX each inpatient Hospital Admission] [$XXX – per individual] [$XXX – per family] [$XXX – per individual]]
[Coinsurance Stop-Loss Amounts] **[Out-of-Pocket Maximum]**	[$XXXX – per individual] [$XXXX – per family]
[Annual Maximum Benefits per Participant]	[$XXXXXX]
Maximum Lifetime Benefits per Participant	[$XXXXXX]
Inpatient Hospital Expenses [All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.]	[Upfront Deductible then] [XX% of Allowable Amount] [after per-admission Deductible] [after Calendar Year Deductible] [No penalty for failure to preauthorize services] [$XXX penalty for failure to preauthorize services]
Medical-Surgical Expenses • [Office visit/consultation, including lab and x-ray] • [Lab & X-ray in Outpatient Facilities] • [Inpatient visits and Certain Diagnostic Procedures] • [Home Infusion Therapy] • [Physician surgical services performed in any setting] • [In-Vitro Fertilization Services] • [Smoking Cessation] [[$XXXX] Lifetime Maximum Smoking Cessation Benefit per Participant applies] [[$XXXX] Annual Maximum Smoking Cessation Benefit per Participant per Calendar Year applies] • [Durable Medical Equipment (DME) [$XXXX] Calendar Year Maximum benefit per Participant]	[Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]] [Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]] [Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]] [Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]] [Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]] [Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]] [Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]] [Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]]

SCHEDULE OF COVERAGE

Plan Provisions	Traditional Medical Benefits
Extended Care Expenses Calendar Year Deductible [applies] [does not apply] ▪ [Skilled Nursing Facility] [$XXXXX Calendar Year maximum] [[XX] days per Calendar Year] ▪ [Home Health Care] [$XXXXXX Calendar Year maximum] [60 visits] ▪ [Hospice Care] [$XXXXX lifetime maximum] [[XX] days Lifetime Maximum]	[Upfront Deductible then] [XX% of Allowable Amount] [after Calendar Year Deductible] [Upfront Deductible then] [XX% of Allowable Amount] [after Calendar Year Deductible] [Upfront Deductible then] [XX% of Allowable Amount] [after Calendar Year Deductible]
Treatment of Chemical Dependency Three separate series of treatments for each covered individual	Covered same as any other sickness
[Serious Mental Illness **Inpatient Services** Hospital services (facility) Physician services [Limited to 45 inpatient days/inpatient visits each Calendar Year] **Outpatient Services** Physician expenses Other outpatient services [Limited to 60 visits each Calendar Year]]	[Upfront Deductible then] [XX% of Allowable Amount [after per-admission Deductible] [after Calendar Year Deductible]] [Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]] [Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]]

SCHEDULE OF COVERAGE

Plan Provisions	Traditional Medical Benefits
[Serious Mental Illness] [Benefits for Public Entity]	[Same as any other physical illness]
[Serious Mental Illness]	[Benefits determined on the same basis as for Mental Health Care]
[Mental Health Care **Inpatient Services** Hospital services (facility) Physician services [Limited to [30] inpatient days/inpatient visits each Calendar Year] **Outpatient Services** Physician expenses Other outpatient services [Limited to [30] visits each Calendar Year]] [Includes treatment for Serious Mental Illness] [$XXXXX] [Calendar Year maximum benefit] [$XXXXX] [lifetime maximum benefit]	[Upfront Deductible then] [XX% of Allowable Amount [after per-admission Deductible] [after Calendar Year Deductible]] [Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]] [Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]]
Emergency Room Treatment Accidental Injury & Emergency Care • Facility Charges • Physician Charges	[Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible] [Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]
[Emergency Room Treatment Non-Emergency Care • Facility Charges • Physician Charges]	[Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]] [Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]]
[Urgent Care Services Services performed in an urgent care facility-including Lab & x-ray (excluding Certain Diagnostic Procedures)]	[Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]]
Ground and Air Ambulance Services	[Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible]

SCHEDULE OF COVERAGE

Plan Provisions	Traditional Medical Benefits
[Preventive Care] [Office visits for routine physical examinations, well baby care, [immunizations for Participants 6 years & over,] [routine lab and x-ray,] [vision exams] [and] hearing exams] [Office services for [immunizations for Participants after 6th birthdate,] [lab & x-ray,] [and] [hearing tests] [$XX maximum benefit amount per Participant per [XX-month] period] [Immunizations for Dependent children through the date of the child's 6th birthday] [Immunizations for Dependent children to age 7 and under]	[Upfront Deductible then] [XX% of Allowable Amount [after Calendar Year Deductible]] [Deductible waived] [100% of Allowable Amount] [Deductible waived]
Speech and Hearing Services, including hearing aids [$XXXX] maximum benefit amount each [XX-Month] period for hearing aids]	[Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible]
Physical Medicine Services [$XXXX] Calendar Year Maximum benefit per Participant] [XX] visits per Participant each Calendar Year]	[Upfront Deductible then] XX% of Allowable Amount [after Calendar Year Deductible]

SCHEDULE OF COVERAGE

[OUTPATIENT PRESCRIPTION DRUG EXPENSES]

Plan Provisions	Participating Pharmacy	Non-Participating Pharmacy
Retail Pharmacy **[One Copayment Amount per 30-day supply,] no more than a [[30][60][90]-day supply]** **[Specialty Drugs – limited to a [30-day supply]**	[XX% of Allowable Amount [after Prescription Drug Deductible] [after Calendar Year Deductible] [$XX Copayment Amount] [after Calendar Year Deductible] – [Generic Drugs] [$XX Copayment Amount] [after Calendar Year Deductible]*] – [Preferred] Brand Name Drug] [$XX Copayment Amount] [after Calendar Year Deductible]*] – [Non-Preferred Brand Name Drug] [$XX Copayment Amount] [XX% of Allowable Amount] [after Calendar Year Deductible] [after Prescription Drug Deductible]**] – [Specialty Drug]	[XX% of Allowable Amount [less any applicable Copayment Amount[*][**] [after Prescription Drug Deductible] [after Calendar Year Deductible]
[Mail Service Pharmacy **[One Copayment Amount per 30-day supply], up to a [[30][60][90]-day supply]**	[XX% of Allowable Amount [after Prescription Drug Deductible] [Calendar Year Deductible] [$XX Copayment Amount] [after Calendar Year Deductible] – [Generic Drugs] [$XX Copayment Amount] [after Calendar Year Deductible]*] – [Preferred Brand Name Drug] [$XX Copayment Amount] [after Calendar Year Deductible]*] – [Non-Preferred Brand Name Drug]	XXXXXXXXXXXXXXXXXXX
[Preferred Specialty Drug Provider **[One Copayment Amount per 30-day supply] – limited to a [30-day supply]]**	[[$XX Copayment Amount] [XX% of Allowable Amount] [after Calendar Year Deductible] [after Prescription Drug Deductible][**] – [Specialty Drug]]	
[Prescription Drug Deductible]	[$XXX per Participant each Calendar Year]	
[Prescription Drug Calendar Year Maximum]	[$XXXX per Participant each Calendar Year]	

SCHEDULE OF COVERAGE

[Prior Authorization Provision]	[Applies]
[Limitations on Quantities Dispensed]	[Applies]
[Diabetes Supplies are available under the Outpatient Prescription Drug Expenses portion of your plan. All provisions of this portion of the Plan will apply including [any Deductibles], [Copayment Amounts] [Coinsurance Amounts], and any pricing differences.]	

[* If you receive a Preferred Brand Name Drug or a Non-Preferred Brand Name Drug when a Generic Drug is available, you may incur additional costs. Refer to the Outpatient Prescription Drug Expenses portion of your booklet for details.]

[** If you receive a brand name drug when a Generic Drug is available, you may incur additional costs. Refer to the Outpatient Prescription Drug Expenses portion of your booklet for details.]

[PRESCRIPTION DRUG PROGRAM]

Plan Provisions	Participating Pharmacy	Non-Participating Pharmacy
Retail Pharmacy **[One Copayment Amount per 30-day supply], up to a [[30][60][90]-day supply]** **[Specialty Drugs – limited to a [30-day supply]**	[$XX] Copayment Amount – [Generic Drugs] [$XX] Copayment Amount[*] – [Preferred Brand Name Drug] [$XX] Copayment Amount[*] – [Non-Preferred Brand Name Drug] [$XX Copayment Amount][**] – [Specialty Drug]	[XX% of Allowable Amount minus Copayment Amount][*][**]
[Mail Service Prescription Drug Program] **[One Copayment Amount per 30-day supply], up to a [[30][60][90]-day] supply**	[$XX] Copayment Amount – [Generic Drugs] [$XX] Copayment Amount[*] – [Preferred Brand Name Drug] [$XX] Copayment Amount[*] – [Non-Preferred Brand Name Drug]	XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXX
[Preferred Specialty Drug Provider **[One Copayment Amount per 30-day supply] – limited to a [30-day supply]]**	[[$XX Copayment Amount] [XX% of Allowable Amount] [after Calendar Year Deductible][after Prescription Drug Deductible]**] – [Specialty Drug]]	
[Prescription Drug Deductible]	[$XXX per Participant each Calendar Year]	
[Prescription Drug Calendar Year Maximum]	[$XXXX per Participant each Calendar Year]	

SCHEDULE OF COVERAGE

[[$XXXX] Lifetime Maximum Smoking Cessation Benefit per Participant applies] **[[$XXXX] Annual Maximum Smoking Cessation Benefit per Participant per Calendar Year applies]**	
[Prior Authorization Provision]	[Applies]
[Step Therapy Provision]	[Applies]
[Limitations on Quantities Dispensed]	[Applies]
[Diabetes Supplies are available under the Prescription Drug Program portion of your plan. All provisions of this portion of the Plan will apply including [any Deductibles], [Copayment Amounts] [Coinsurance Amounts], and any pricing differences.]	

[* If you receive a Preferred Brand Name Drug or a Non-Preferred Brand Name Drug when a Generic Drug is available, you may incur additional costs. Refer to the Prescription Drug Program portion of your booklet for details.]

[** If you receive a brand name drug when a Generic Drug is available, you may incur additional costs. Refer to the Prescription Drug Program portion of your booklet for details.]

SCHEDULE OF COVERAGE

Dependent Child Age Limit to [25]

Dependent children are [eligible] [not eligible] for Maternity Care benefits

Preexisting Conditions
[Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be available during the [3][6][9][12]-month period following the initial Effective Date. This Preexisting Condition waiting period begins on the Effective Date of the Participant's coverage under the Plan. Credit will be given for time served under Creditable Coverage.]

[The Preexisting Conditions waiting period is waived on initial enrollment]

[Preexisting Conditions are covered immediately]

[Preexisting Conditions for Late Enrollees will be covered after a waiting period of 12 months]

[Waiting Period
[The Waiting Period for eligibility is shown on your Schedule of Coverage.] [The Waiting Period is waived on initial group enrollment]

INTRODUCTION

This Plan is offered by your Employer as one of the benefits of your employment. The benefits provided are intended to assist you with many of your health care expenses for Medically Necessary services and supplies. There are provisions throughout this Benefit Booklet that affect your health care coverage. It is important that you read the Benefit Booklet carefully so you will be aware of the benefits and requirements of this Plan. In the event of any conflict between any components of this Plan, the Schedule of Specifications provided to your Employer by BCBSTX prevails.

The defined terms in this Benefit Booklet are capitalized and shown in the appropriate provision in the Benefit Booklet or in the **DEFINITIONS** section of the Benefit Booklet. Whenever these terms are used, the meaning is consistent with the definition given. Terms in italics may be section headings describing provisions or they may be defined terms.

The terms "you" and "your" as used in this Benefit Booklet refer to the Employee. Use of the masculine pronoun "his," "he," or "him" will be considered to include the feminine unless the context clearly indicates otherwise.

[Managed Health Care In-Network Benefits

To receive In-Network Benefits as indicated on your Schedule of Coverage, **you must** choose Providers within the Network for all care **(other than for emergencies**). The Network has been established by BCBSTX and consists of Physicians, Specialty Care Providers, Hospitals, and other health care facilities to serve Participants throughout the Network Plan Service Area. Refer to your Provider directory or visit the BCBSTX website at www.bcbstx.com to make your selections. The listing may change occasionally, so make sure the Providers you select are still Network Providers. An updated directory will be available at least annually or you may access our website, www.bcbstx.com, for the most current listing to assist you in locating a Provider.

To receive In-Network Benefits for [Mental Health Care,] Serious Mental Illness, or treatment of Chemical Dependency, all care should be preauthorized by calling the toll-free Mental Health Helpline indicated on your Identification Card and in this Benefit Booklet. Services and supplies for [Mental Health Care,] Serious Mental Illness, or treatment of Chemical Dependency must be provided by Network Providers that have specifically contracted with BCBSTX to furnish services and supplies for those types of conditions to be considered for In-Network Benefits.

If you choose a Network Provider, the Provider will bill BCBSTX - not you - for services provided.

The Provider has agreed to accept as payment in full the least of...

- The billed charges, or
- The Allowable Amount as determined by BCBSTX, or
- Other contractually determined payment amounts.

You are responsible for paying any [Deductibles ,] [Copayment Amounts[,] [and] Coinsurance Amounts. You may be required to pay for limited or non-covered services. No claim forms are required.

Managed Health Care Out-of-Network Benefits

If you choose Out-of-Network Providers, only Out-of-Network Benefits will be available. If you go to a Provider outside the Network, benefits will be paid at the Out-of-Network Benefits level. If you choose a health care Provider outside the Network, you may have to submit claims for the services provided.

You will be responsible for…

- Billed charges above the Allowable Amount as determined by BCBSTX,

- Coinsurance Amounts[, and Deductibles],
- Preauthorization, and
- Limited or non-covered services.]

[Traditional Medical Benefits

Traditional Medical Benefits coverage provides benefits as explained in the **COVERED MEDICAL SERVICES** section and shown on your Schedule of Coverage in this Benefit Booklet.

You may have to submit claims for the services provided and *you will be responsible for*…

- Billed charges above the Allowable Amount as determined by BCBSTX,
- Coinsurance Amounts[, and Deductibles],
- Preauthorization, and
- Limited or non-covered services.]

[Prescription Drug [Program] Benefits

Benefits are provided for those Covered Drugs as explained in the **[PRESCRIPTION DRUG PROGRAM][OUTPATIENT PRESCRIPTION DRUG EXPENSES]** section and shown on your Schedule of Coverage in this Benefit Booklet. The amount of your payment under the Plan depends on whether:

- the Prescription Order is filled at a Participating Pharmacy or at a Non-Participating Pharmacy[;] [or through the Mail Service Prescription Drug Program];
- [the Prescription Order is filled by a provider contracting with BCBSTX;]
- a Generic Drug [or brand name drug] is dispensed;
- [a Preferred or Non-Preferred Brand Name Drug is dispensed;]
- [a Specialty Drug is dispensed;]
- [your Plan includes a separate Prescription Drug Deductible;] or
- [your Plan includes a Prescription Drug Calendar Year Maximum benefit amount].]

Important Contact Information

Resource	Contact Information	Accessible Hours
Customer Service Helpline	**1-800-521-2227**	**Monday – Friday 8:00 a.m. – 8:00 p.m.**
Website	**www.bcbstx.com**	**24 hours a day 7 days a week**
Medical Preauthorization Helpline	**1-800-441-9188**	**Monday – Friday 7:30 a.m. – 6:00 p.m.**
Mental Health Helpline	**1-800-528-7264**	**24 hours a day 7 days a week**

Customer Service Helpline

Customer Service Representatives can:

- [Identify your Plan Service Area]
- Give you information about [Network][and] *ParPlan*[, and other] Providers [contracting with BCBSTX]
- Distribute claim forms
- Answer your questions on claims

- [Assist you in identifying a Network Provider (but will not recommend specific Network Providers)]
- Provide information on the features of the Plans
- Record comments about Providers
- [Assist you with questions regarding the **PRESCRIPTION DRUG PROGRAM]**
- [Assist you with questions regarding **OUTPATIENT PRESCRIPTION DRUG EXPENSES]**

BCBSTX Website

Visit the BCBSTX website at www.bcbstx.com for information about BCBSTX, access to forms referenced in this Benefit Booklet, and much more.

Mental Health Helpline

To satisfy preauthorization requirements for Participants seeking treatment for [Mental Health Care,] Serious Mental Illness, or Chemical Dependency, you, your Physician, Provider of services, or a family member may call the Mental Health Helpline at any time, day or night.

Medical Preauthorization Helpline

To satisfy all medical preauthorization requirements for inpatient Hospital Admissions, Extended Care Expenses, or Home Infusion Therapy, call the Medical Preauthorization Helpline.

WHO GETS BENEFITS

Eligibility Requirements for Coverage

The Eligibility Date is the date a person becomes eligible to be covered under the Plan. A person becomes eligible to be covered when he becomes an Employee or a Dependent and is in a class eligible to be covered under the Plan. The Eligibility Date is:

1. The date the Employee, including any Dependents to be covered, completes the Waiting Period, if any, for coverage;

2. Described in the ***Dependent Enrollment Period*** section for a new Dependent of an Employee already having coverage under the Plan.

Employee Eligibility
Any person eligible under this Contract and covered by the Employer's previous Health Benefit Plan on the date prior to the Contract Date, including any person who has continued group coverage under applicable federal or state law, is eligible on the Contract Date. Otherwise, you are eligible for coverage under the Plan when you satisfy the definition of an Employee [and you reside or work in the Plan Service Area].

[Employees who have retired under the Large Employer's established procedures whereby individual selection by the Large Employer or the Employee to be included in a retiree classification is precluded, may continue coverage under this Contract.]

Dependent Eligibility
If you apply for coverage, you may include your Dependents. Eligible Dependents are:
1. Your spouse;
2. An unmarried child under the limiting age shown in the Schedule of Coverage;
3. Any unmarried child of any age who is medically certified as Disabled and dependent on the parent;
4. A child of your child who is your Dependent for federal income tax purposes at the time application for coverage of the child is made;
5. Any other child included as an eligible Dependent under the Contract. A detailed description of Dependent is in the **DEFINITIONS** section of this Benefit Booklet.

An Employee must be covered first in order to cover his eligible Dependents. No Dependent shall be covered hereunder prior to the Employee's Effective Date. If you are married to another Employee, you may not cover your spouse as a Dependent, and only one of you may cover any Dependent children. However, if you are a school district Employee who is eligible for coverage under this Health Benefit Plan (Plan) and you are the spouse of another school district Employee also eligible for coverage under this same Plan, you may elect whether to be treated under the Plan as an Employee or the Dependent of the other Employee.

Effective Dates of Coverage

In order for an Employee's coverage to take effect, the Employee must submit written enrollment for coverage for himself and any Dependents.

The Effective Date is the date the coverage for a Participant actually begins. The Effective Date under the Contract is shown on your Identification Card. It may be different from the Eligibility Date.

WHO GETS BENEFITS

Timely Applications
It is important that your application for coverage under the Plan is received timely by the Carrier.

If you apply for coverage and pay any required premium for yourself or for yourself and your eligible Dependents and if you:

1. Are eligible on the Contract Date and the application is received by the Carrier prior to or within 31 days following such date, your coverage will become effective on the Contract Date;

2. Enroll for coverage for yourself or for yourself and your Dependents during an Open Enrollment Period, coverage shall become effective on the Contract Anniversary; and

3. Become eligible after the Contract Date and if the application is received by the Carrier within the first 31 days following your Eligibility Date, the coverage will become effective as provided in the Contract (see your Employer for this Effective Date information).

Effective Dates - Delay of Benefits Provided
Coverage becomes effective for you and/or your Dependents on the Contract Date upon completion of an application for coverage. If you or your eligible Dependent(s) are confined in a Hospital or Facility Other Provider on the Contract Date, your coverage is effective on the Contract Date. However, if this Contract is replacing a discontinued Health Benefit Plan or self-funded Health Benefit Plan, benefits for any Employee or Dependent may be delayed until the expiration of any applicable extension of benefits provided by the previous Health Benefit Plan or self-funded Health Benefit Plan.

Effective Dates - Late Enrollee
If your application is not received within 31 days from the Eligibility Date, you will be considered a Late Enrollee. You will become eligible to apply for coverage during your Employer's next Open Enrollment Period. Your coverage will become effective on the Contract Anniversary. If you are a Late Enrollee, you may be subject to a 12-month Preexisting Condition limitation beginning on the Contract Anniversary.

Loss of Other Health Insurance Coverage

An Employee who is eligible, but not enrolled for coverage under the terms of the Plan (or/and a Dependent, if the Dependent is eligible, but not enrolled for coverage under such terms) shall become eligible to apply for coverage if each of the following conditions is met:

1. The Employee or Dependent were covered under a Health Benefit Plan, self-funded Health Benefit Plan, or had other health insurance coverage at the time this coverage was previously offered; and

2. Coverage was declined under this Plan in writing, on the basis of coverage under another Health Benefit Plan or self-funded Health Benefit Plan; and

3. There is a loss of coverage under such prior Health Benefit Plan or self-funded Health Benefit Plan as a result of:

    a. Exhaustion of continuation under Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended and/or State continuation under the *Texas Insurance Code*; or

    b. Cessation of Dependent status (such as divorce or attaining the maximum age to be eligible as a dependent child under the Plan), termination of employment, a reduction in the number of hours of employment, or employer contributions toward such coverage were terminated; or

c. Termination of the other plan's coverage, a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits, a situation in which the other plan no longer offers any benefits to the class of similarly situated individuals that include you or your Dependent, or, in the case of coverage offered through an HMO, you or your Dependent no longer reside, live, or work in the service area of that HMO and no other benefit option is available; and

4. You request to enroll no later than 31 days after the date coverage ends under the prior Health Benefit Plan or self-funded Health Benefit Plan or, in the event of the attainment of a lifetime limit on all benefits, the request to enroll is made not later than 31 days after a claim is denied due to the attainment of a lifetime limit on all benefits. Coverage will become effective the first day of the calendar month following receipt of the application by the Carrier.

If all conditions described above are not met, you will be considered a Late Enrollee.

Dependent Enrollment Period

1. ***Special Enrollment Period for Newborn***
   Coverage of a newborn child will be automatic for the first 31 days following the birth of your newborn child [or your Dependent daughter's newborn child]. For coverage to continue beyond this time, you [or your Dependent daughter] must notify the Carrier within 31 days of birth and pay any required premium within that 31-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of birth. If the Carrier is notified after that 31-day period, the newborn child's coverage will become effective on the Contract Anniversary following the Employer's next Open Enrollment Period.

2. ***Special Enrollment Period for Adopted Children or Children Involved in a Suit for Adoption***
   Coverage of an adopted child or child involved in a suit for adoption will be automatic for the first 31 days following the adoption or date on which a suit for adoption is sought. For coverage to continue beyond this time, the Carrier must receive all necessary forms and the required premium within the 31-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of adoption or date on which a suit for adoption is sought. If you notify the Carrier after that 31-day period, the child's coverage will become effective on the Contract Anniversary following the Employer's next Open Enrollment Period.

3. ***Court Ordered Dependent Children***
   If a court has ordered an Employee to provide coverage for a child, coverage will be automatic for the first 31 days after the date your Employer receives notification of the court order. To continue coverage beyond the 31 days, the Carrier must receive all necessary forms and the required premium within the 31-day period. If you notify the Carrier after that 31-day period, the Dependent child's coverage will become effective on the Contract Anniversary following your Employer's next Open Enrollment Period.

4. ***Court Ordered Coverage for a Spouse***
   If a court has ordered you, the Employee, to provide coverage for a spouse, written enrollment must be received within 31 days after issuance of the court order. Coverage will become effective on the first day of the month following the date the application for coverage is received and the required premium is paid within the 31-day period. If application is not made within the initial 31 days, your spouse's coverage will become effective on the Contract Anniversary following your Employer's next Open Enrollment Period.

5. ***Other Dependents***
   Written application must be received within 31 days of the date that a spouse or child first qualifies as a Dependent. If the written application is received within 31 days, coverage will become effective on the date the child or spouse first becomes an eligible Dependent. If application is not made within the initial 31 days, then your Dependent's coverage will become effective on the Contract Anniversary following your Employer's Open Enrollment Period.

If you ask that your Dependent be insured after having canceled his or her coverage while your Dependent was still entitled to coverage, your Dependent's coverage will become effective in accordance with the provisions for Late Enrollees.

In no event will your Dependent's coverage become effective prior to your Effective Date.

Other Employee Enrollment Period

1. As a special enrollment period event, if you acquire a Dependent through birth, adoption, or through suit for adoption, and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage***, as described above, you may apply for coverage for yourself, your spouse, and a newborn child, adopted child, or child involved in a suit for adoption. If the written application is received within 31 days of the birth, adoption, or suit for adoption, coverage for the child, you, or your spouse will become effective on the date of the birth, adoption, or date suit for adoption is sought.

   If you marry and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage*** as described above, you may apply for coverage for yourself and your spouse. If the written application is received within 31 days of the marriage, coverage for you and your spouse will become effective on the first day of the month following receipt of the application by the Carrier.

2. If you are required to provide coverage for a child as described in ***Court Ordered Dependent Children*** above, and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage***, you may apply for coverage for yourself. If the written application is received within 31 days of the date your Employer receives notification of the court order, coverage for you will become effective on the date your Employer receives notification of the court order.

Group Enrollment Application/Change Form

Use this form to...

- Notify the Plan and BCBSTX of a change to your name
- Add Dependents (other than a newborn child where notification only is required)
- Drop Dependents
- Cancel all or a portion of your coverage
- Notify BCBSTX of all changes in address for yourself and your Dependents. [An address change may result in benefit changes for you and your Dependents if you move out of the Plan Service Area of the Network.]

You may obtain this form from your Employer, by calling the BCBSTX Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card, or by accessing the BCBSTX website. If a Dependent's address and zip code are different from yours, be sure to indicate this information on the form. After you have completed the form, return it to your Employer.

Changes in Your Family

You should promptly notify the Carrier in the event of a birth or follow the instructions below when events, such as but not limited to, the following take place:

- If you are adding a Dependent due to marriage, adoption, or a child being involved in a suit for which an adoption of the child is sought, or your Employer receives a court order to provide health coverage for a Participant's child or your spouse, you must submit an *Group Enrollment Application/Change Form* and the coverage of the Dependent will become effective as described in ***Dependent Enrollment Period***.

- When you divorce, your child marries or reaches the age indicated on the Schedule of Coverage as "Dependent child age limit," or a Participant in your family dies, coverage under the Plan terminates in accordance with the **Termination of Coverage** provisions selected by your Employer.

Notify your Employer promptly if any of these events occur. Benefits for expenses incurred after termination are not available. If your Dependent's coverage is terminated, premium refunds will not be made for any period before the date of notification. If benefits are paid prior to notification to BCBSTX, refunds will be requested.

Please refer to the **Continuation Privilege** subsection in this Benefit Booklet for additional information.

Allowable Amount

The Allowable Amount is the maximum amount of benefits BCBSTX will pay for Eligible Expenses you incur under the Plan. BCBSTX has established an Allowable Amount for Medically Necessary services, supplies, and procedures provided by Providers that have contracted with BCBSTX or any other Blue Cross and/or Blue Shield Plan, and Providers that have not contracted with BCBSTX or any other Blue Cross and/or Blue Shield Plan. When you choose to receive services, supplies, or care from a Provider that does not contract with BCBSTX, you will be responsible for any difference between the BCBSTX Allowable Amount and the amount charged by the non-contracting Provider. You will also be responsible for charges for services, supplies, and procedures limited or not covered under the Plan[,] [and] [Deductibles,] any applicable [Coinsurance Stop-Loss Amounts][,] [Out-of-Pocket Maximum amounts][,] [and] [Copayment Amounts].

Review the definition of Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet to understand the guidelines used by BCBSTX.

Case Management

Under certain circumstances, the Plan allows BCBSTX the flexibility to offer benefits for expenses which are not otherwise Eligible Expenses. BCBSTX, at its sole discretion, may offer such benefits if:

- The Participant, his family, and the Physician agree;
- Benefits are cost effective; and
- BCBSTX anticipates future expenditures for Eligible Expenses which may be reduced by such benefits.

Any decision by BCBSTX to provide such benefits shall be made on a case-by-case basis. The case coordinator for BCBSTX will initiate case management in appropriate situations.

[Continuity of Care

In the event a Participant is under the care of a Network Provider at the time such Provider stops participating in the Network and at the time of the Network Provider's termination, the Participant has *special circumstances* such as a (1) disability, (2) acute condition, (3) life-threatening illness, or (4) is past the 24th week of pregnancy and is receiving treatment in accordance with the dictates of medical prudence, BCBSTX will continue providing coverage for that Provider's services at the In-Network Benefit level.

Special circumstances means a condition such that the treating Physician or health care Provider reasonably believes that discontinuing care by the treating Physician or Provider could cause harm to the Participant. *Special circumstances* shall be identified by the treating Physician or health care Provider, who must request that the Participant be permitted to continue treatment under the Physician's or Provider's care and agree not to seek payment from the Participant of any amounts for which the Participant would not be responsible if the Physician or Provider were still a Network Provider.

The continuity of coverage under this subsection will not extend for more than ninety (90) days, or more than nine (9) months if the Participant has been diagnosed with a terminal illness, beyond the date the Provider's termination from the Network takes effect. However, for Participants past the 24th week of pregnancy at the time the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery.]

[Freedom of Choice

Each time you need medical care, you can choose to:		
See a Network Provider	***See an Out-of-Network Provider***	
	***ParPlan* Provider** *(refer to **ParPlan**, below, for more information)*	**Out-of-Network Provider that is not a contracting Provider**
• You receive the higher level of benefits (In-Network Benefits) • You are not required to file claim forms • You are not balance billed; Network Providers will not bill for costs exceeding the BCBSTX Allowable Amount for covered services • Your Provider will preauthorize necessary services	• You receive the lower level of benefits (Out-of-Network Benefits) • You are not required to file claim forms in most cases; *ParPlan* Providers will usually file claims for you • You are not balance billed; *ParPlan* Providers will not bill for costs exceeding the BCBSTX Allowable Amount for covered services • In most cases, *ParPlan* Providers will preauthorize necessary services	• You receive Out-of-Network Benefits (the lower level of benefits) • You are required to file your own claim forms • You may be billed for charges exceeding the BCBSTX Allowable Amount for covered services • You must preauthorize necessary services]

Identification Card

The Identification Card tells Providers that you are entitled to benefits under your Employer's Health Benefit Plan with BCBSTX. The card offers a convenient way of providing important information specific to your coverage including, but not limited to, the following:

- ***Your Subscriber identification number***. This unique identification number is preceded by a three character alpha prefix that identifies Blue Cross and Blue Shield of Texas as your Carrier.
- ***Your group number***. This is the number assigned to identify your Employer's Health Benefit Plan with BCBSTX.
- ***[Any Copayment Amounts that may apply to your coverage***.]
- ***Important telephone numbers***.

Always remember to carry your Identification Card with you and present it to your Providers [or Participating Pharmacies] when receiving health care services or supplies.

Please remember that any time a change in your family takes place it may be necessary for a new Identification Card to be issued to you (refer to the **WHO GETS BENEFITS** section for instructions when changes are made). Upon receipt of the change in information, the Carrier will provide a new Identification Card.

Unauthorized, Fraudulent, Improper, or Abusive Use of Identification Cards

1. The unauthorized, fraudulent, improper, or abusive use of Identification Cards issued to you and your covered Dependents will include, but not be limited to, the following actions, when intentional:

    a. Use of the Identification Card prior to your Effective Date;
    b. Use of the Identification Card after your date of termination of coverage under the Plan;
    c. Obtaining [prescription drugs or other] benefits for persons not covered under the Plan;
    d. Obtaining [prescription drugs or other] benefits that are not covered under the Plan;
    e. [Obtaining Covered Drugs for resale or for use by any person other than the person for whom the Prescription Order is written, even though the person is otherwise covered under the Plan;]

f. [Obtaining Covered Drugs without a Prescription Order or through the use of a forged or altered Prescription Order;]
g. [Obtaining quantities of prescription drugs in excess of Medically Necessary or prudent standards of use or in circumvention of the quantity limitations of the Plan;
h. Obtaining prescription drugs using Prescription Orders for the same drugs from multiple Providers;
i. Obtaining prescription drugs from multiple Pharmacies through use of the same Prescription Order.]

2. The fraudulent or intentionally unauthorized, abusive, or other improper use of Identification Cards by any Participant can result in, but is not limited to, the following sanctions being applied to all Participants covered under your coverage:

   a. Denial of benefits;
   b. Cancellation of coverage under the Plan for **all** Participants under your coverage;
   c. Limitation on the use of the Identification Card to one designated Physician, Other Provider, [or Participating Pharmacy] of your choice;
   d. Recoupment from you or any of your covered Dependents of any benefit payments made;
   e. Pre-approval of [drug purchases and] medical services for all Participants receiving benefits under your coverage;
   f. Notice to proper authorities of potential violations of law or professional ethics.

Medical Necessity

All services and supplies for which benefits are available under the Plan must be Medically Necessary as determined by BCBSTX. Charges for services and supplies which BCBSTX determines are not Medically Necessary will not be eligible for benefit consideration and may not be used [to satisfy Deductibles or] to apply to the [Coinsurance Stop-Loss Amount] [Out-of-Pocket Maximum].

ParPlan

When you consult a Physician or Professional Other Provider [who does not participate in the Network], you should inquire if he participates in the Carrier's *ParPlan.*..a simple direct-payment arrangement. If the Physician or Professional Other Provider participates in *ParPlan*, he agrees to:

- File all claims for you,
- Accept the Carrier's Allowable Amount determination as payment for Medically Necessary services, and
- Not bill you for services over the Allowable Amount determination.

You will [receive Out-of-Network Benefits and] be responsible for:

- [Any Deductibles,]
- Coinsurance Amounts, and
- Services that are limited or not covered under the Plan.

Note: If you have a question regarding a Physician's or Professional Other Provider's participation in *ParPlan*, please contact the BCBSTX Customer Service Helpline.

Preexisting Conditions Provision

[Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will be available immediately with no Preexisting Condition waiting period.]

[Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be available during the [three] [six] [nine] [twelve]-month period following the Participant's initial Effective Date.

The Preexisting Condition exclusion **will not apply** to:

1. A newborn child who is added as described in ***Dependent Enrollment Period*** within the first 31 days after the date of birth; or

2. A child who is adopted or involved in a suit for adoption before attaining the limiting age shown in the Schedule of Coverage and who applies, as described in ***Dependent Enrollment Period***, for coverage under this Contract; or

3. A court ordered Dependent of a covered Employee who applies for coverage as described in ***Dependent Enrollment Period***; or

4. An individual who was continuously covered for an aggregate period of twelve months under Creditable Coverage that was in effect up to a date not more than 63 days before the Effective Date of coverage under the Health Benefit Plan, excluding any Waiting Periods.

The Carrier will credit the time you were covered under Creditable Coverage if the previous coverage was in effect under a Health Benefit Plan or self-funded Health Benefit Plan at any time during the twelve months prior to the Effective Date of coverage under this Plan. If the previous coverage was issued under a Health Benefit Plan, any waiting period that applied before that coverage became effective also will be credited against the Preexisting Condition exclusion.

Pregnancy, conditions resulting from domestic violence, and genetic information without a diagnosis of a specific condition shall not be considered a Preexisting Condition. All other terms, provisions, limitations, and exclusions will apply to all Participants even if any Preexisting Condition exclusion is not applicable for the reasons set out above.]

[Specialty Care Providers

A wide range of Specialty Care Providers is included in the Network. When you need a specialist's care, In-Network Benefits will be available, but only if you use a Network Provider.

There may be occasions however, when you need the services of an Out-of-Network Provider. This could occur if you have a complex medical problem that cannot be taken care of by a Network Provider.

- If the services you require are not available from Network Providers, In-Network Benefits will be provided when you use Out-of-Network Providers. Refer to the Allowable Amount Notice in the **NOTICES** section of this Benefit Booklet for additional information.

- If you elect to see an Out-of-Network Provider and if the services could have been provided by a Network Provider, only Out-of-Network Benefits will be available.]

PREAUTHORIZATION REQUIREMENTS

Preauthorization Requirements

Preauthorization establishes in advance the Medical Necessity of certain care and services covered under this Plan. It ensures that the preauthorized care and services described below will not be denied on the basis of Medical Necessity. However, preauthorization does not guarantee payment of benefits.

Coverage is always subject to other requirements of the Plan, such as [Preexisting Conditions,] limitations and exclusions, payment of premium, and eligibility at the time care and services are provided.

To satisfy preauthorization requirements, you, your Physician, Provider of services, or a family member calls one of the toll-free numbers listed on the back of your Identification Card. The call for preauthorization should be made between 7:30 a.m. and 6:00 p.m. on business days. Calls made after working hours or on weekends will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. All timelines for preauthorization requirements are provided in keeping with applicable state and federal regulations**.**

The following types of services require preauthorization:

- All inpatient Hospital Admissions,
- Extended Care Expense,
- Home Infusion Therapy,
- All inpatient [and outpatient] treatment of Chemical Dependency,
- All inpatient [and outpatient] treatment of Serious Mental Illness and Mental Health Care,
- If you transfer to another facility or to or from a specialty unit within the facility.

[In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. In-Network Providers will preauthorize services for you, when required.

If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid.]

You are responsible for ensuring that preauthorization requirements are satisfied. Failure to preauthorize services will be subject to guidelines described in the paragraph entitled ***Failure to Preauthorize***.

[However, if care is not available from Network Providers as determined by BCBSTX, and BCBSTX acknowledges your visit to an Out-of-Network Provider **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of Network Benefits will be paid and the claim will have to be resubmitted for review and adjustment, if appropriate.]

Failure to Preauthorize

If preauthorization for inpatient Hospital Admissions, Extended Care Expense, Home Infusion Therapy, Chemical Dependency, Serious Mental Illness, [and] [Mental Health Care] as described above, is not obtained:

- BCBSTX will review the Medical Necessity of your treatment prior to the final benefit determination.

- If BCBSTX determines the treatment or service is not Medically Necessary, benefits will be reduced or denied; or

- In connection with an inpatient Hospital Admission, you may be responsible for a penalty, if indicated on your Schedule of Coverage. The penalty charge will be deducted from any benefit payment which may be due for the inpatient admission.

PREAUTHORIZATION REQUIREMENTS

- If an inpatient Hospital Admission or extension for any treatment or service described below is not preauthorized and it is determined that the admission or extension was not Medically Necessary, benefits will be reduced or denied.

Preauthorization for Inpatient Hospital Admissions
In the case of an elective inpatient Hospital Admission, the call for preauthorization should be made at least two working days before you are admitted unless it would delay Emergency Care. In an emergency, preauthorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

When an inpatient Hospital Admission is preauthorized, a length-of-stay is assigned. Your Plan is required to provide a minimum length of stay in a Hospital facility for the following:

- Maternity Care
  - 48 hours following an uncomplicated vaginal delivery
  - 96 hours following an uncomplicated delivery by caesarean section
- Treatment of Breast Cancer
  - 48 hours following a mastectomy
  - 24 hours following a lymph node dissection

If you require a longer stay than was first preauthorized, your Provider may seek an extension for the additional days. Benefits will not be available for room and board charges for medically unnecessary days.

Preauthorization for Extended Care Expense and Home Infusion Therapy
Preauthorization for Extended Care Expense and Home Infusion Therapy may be obtained by having the agency or facility providing the services contact BCBSTX to request preauthorization. The request should be made:

- Prior to initiating Extended Care Expense or Home Infusion Therapy;
- When an extension of the initially preauthorized service is required; and
- When the treatment plan is altered.

BCBSTX will review the information submitted prior to the start of Extended Care Expense or Home Infusion Therapy and will send a letter to you and the agency or facility confirming preauthorization or denying benefits. If Extended Care Expense or Home Infusion Therapy is to take place in less than one week, the agency or facility should call the BCBSTX **Medical Preauthorization Helpline** telephone number indicated in this Benefit Booklet or shown on your Identification Card.

If BCBSTX has given notification that benefits for the treatment plan requested will be denied based on information submitted, claims will be denied.

Preauthorization for Chemical Dependency, Serious Mental Illness, [Mental Health Care]
[All inpatient and outpatient] treatment of Chemical Dependency, [and] Serious Mental Illness, [and] [Mental Health Care] should be preauthorized.]

[All inpatient treatment of Chemical Dependency, [and] Serious Mental Illness, [and] [Mental Health Care] should be preauthorized.]

CLAIM FILING PROCEDURES

Filing of Claims Required

Notice of Claim
You must give written notice to BCBSTX within 20 days, or as soon as reasonably possible, after any Participant receives services for which benefits are provided under the Plan. Failure to give notice within this time will not invalidate or reduce any claim if you show that it was not reasonably possible to give notice and that notice was given as soon as it was reasonably possible.

Claim Forms
When BCBSTX receives notice of claim, it will furnish to you, or to your Employer for delivery to you, the Hospital, or your Physician or Professional Other Provider, the claim forms that are usually furnished by it for filing Proof of Loss. If the forms are not furnished within 15 days after receipt of notice by BCBSTX, you have complied with the requirements of the Plan for Proof of Loss by submitting, within the time fixed under the Plan for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

BCBSTX must receive claims prepared and submitted in the proper manner and form, in the time required, and with the information requested before it can consider any claim for payment of benefits.

Who Files Claims

Providers that contract with BCBSTX and some other health care Providers (such as *ParPlan* Providers) will submit your claims directly to BCBSTX for services provided to you or any of your covered Dependents. At the time services are provided, inquire if they will file claim forms for you. To assist Providers in filing your claims, you should carry your Identification Card with you.

Contracting Providers
When you receive treatment or care from a Provider [or Covered Drugs dispensed from a Pharmacy] that contracts with BCBSTX, you will generally not be required to file claim forms. The Provider will usually submit the claims directly to BCBSTX for you.

Non-Contracting Providers
When you receive treatment or care from a health care Provider [or Covered Drugs dispensed from a Pharmacy] that does not contract with BCBSTX, you may be required to file your own claim forms. Some Providers, however, will do this for you. If the Provider does not submit claims for you, refer to the subsection entitled ***Participant-filed claims*** below for instruction on how to file your own claim forms.

[Mail Service [Pharmacy][Prescription Drug Program]
When you receive Covered Drugs dispensed through the Mail Service [Pharmacy] [Prescription Drug Program], you must complete and submit the mail service prescription drug claim form to the address on the claim form. Additional information may be obtained from your Employer, from the Carrier, off of the BCBSTX website, or by calling the Customer Service Helpline.]

Participant-filed claims
- Medical Claims
  If your Provider does not submit your claims, you will need to submit them to BCBSTX using a Subscriber-filed claim form provided by BCBSTX. Your Employer should have a supply of claim forms or you can obtain copies from the BCBSTX website. Follow the instructions on the reverse side of the form to complete the claim. Remember to file each Participant's expenses separately because any Deductibles, maximum benefits, and other provisions are applied to each Participant separately. Include itemized bills from the

health care Providers, labs, etc., printed on their letterhead and showing the services performed, dates of service, charges, and name of the Participant involved.

- [Prescription Drug Claims
  When you receive Covered Drugs dispensed from a [Participating] [or] Non-Participating Pharmacy, a *Prescription Reimbursement Claim Form* must be submitted. This form can be obtained from the Carrier or your Employer. This claim form, accompanied by an itemized bill obtained from the Pharmacy showing the prescription services you received, should be mailed to the address shown below or on the claim form.

  Instructions for completing the claim form are provided on the back of the form. You may need to obtain additional information, which is not on the receipt from the pharmacist, to complete the claim form.

  Bills for Covered Drugs should show the name, address, and telephone number of the pharmacy, a description and quantity of the drug, the prescription number, the date of purchase and most importantly, the name of the Participant using the drug.]

VISIT THE BCBSTX WEBSITE FOR SUBSCRIBER CLAIM FORMS AND OTHER USEFUL INFORMATION
www.bcbstx.com

Where to Mail Completed Claim Forms

Medical Claims
Blue Cross and Blue Shield of Texas
[Claims Division
P. O. Box 660044
Dallas, Texas 75266-0044]

[Prescription Drug Claims
Blue Cross and Blue Shield of Texas
[c/o Prime Therapeutics LLC
P. O. Box 64812
St. Paul, MN 55164-0812]

[***Mail Service Pharmacy***
Blue Cross and Blue Shield of Texas
[c/o PrimeMail Pharmacy
P. O. Box 650041
Dallas, Texas 75265-0041]]

Who Receives Payment

Benefit payments will be made directly to contracting Providers when they bill BCBSTX. Written agreements between BCBSTX and some Providers may require payment directly to them. Any benefits payable to you, if unpaid at your death, will be paid to your beneficiary or to your estate, if no beneficiary is named.

Except as provided in the section **Assignment and Payment of Benefits,** rights and benefits under the Plan are not assignable, either before or after services and supplies are provided.

Benefit Payments to a Managing Conservator
Benefits for services provided to your minor Dependent child may be paid to a third party if:

- the third party is named in a court order as managing or possessory conservator of the child; and
- BCBSTX has not already paid any portion of the claim.

In order for benefits to be payable to a managing or possessory conservator of a child, the managing or possessory conservator must submit to BCBSTX, with the claim form, proof of payment of the expenses and a certified copy of the court order naming that person the managing or possessory conservator.

BCBSTX may deduct from its benefit payment any amounts it is owed by the recipient of the payment. Payment to you or your Provider, or deduction by BCBSTX from benefit payments of amounts owed to BCBSTX, will be considered in satisfaction of its obligations to you under the Plan.

An *Explanation of Benefits* summary is sent to you so you will know what has been paid.

When to Submit Claims

All claims for benefits under the Plan must be properly submitted within 90 days of the date you receive the services or supplies. Claims not submitted and received by BCBSTX within twelve (12) months after that date will not be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by BCBSTX

A claim will be considered received by BCBSTX for processing upon actual delivery to the BCBSTX Administrative Office in the proper manner and form and with all of the information required. If the claim is not complete, it may be denied or BCBSTX may contact either you or the Provider for the additional information.

REVIEW OF CLAIM DETERMINATIONS

Claim Determinations

When BCBSTX receives a properly submitted claim, it has authority and discretion under the Plan to interpret and determine benefits in accordance with the Plan provisions. BCBSTX will render an initial decision to pay or deny a claim within 30 days of receipt of the claim. If BCBSTX requires further information in order to process the claim, we will request it within that 30-day period.

You have the right to seek and obtain a full and fair review by BCBSTX of any determination of a claim, any determination of a request for preauthorization, or any other determination made by BCBSTX of your benefits under the Plan.

If a Claim Is Denied or Not Paid in Full
On occasion, BCBSTX may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the *Explanation of Benefits* summary prepared by BCBSTX; then review this Benefit Booklet to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to BCBSTX and request a review of the decision. Include your full name, group and subscriber numbers with the request.

If the claim is denied in whole or in part, you will receive a written notice from BCBSTX with the following information, if applicable:

- The reasons for denial;
- A reference to the health care plan provisions on which the denial is based;
- A description of additional information which may be necessary to complete the claim and an explanation of why such information is necessary; and
- An explanation of how you may have the claim reviewed by BCBSTX if you do not agree with the denial.

Right to Review Claim Determinations
If you believe BCBSTX incorrectly denied all or part of your benefits, you may have your claim reviewed. BCBSTX will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of a denial or partial denial, write to BCBSTX's Administrative Office. BCBSTX will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

  Claim Review Section
  [Blue Cross and Blue Shield of Texas
  P. O. Box 660044
  Dallas, Texas 75266-0044]

- You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.

- BCBSTX will honor telephone requests for information, however, such inquiries will not constitute a request for review.

- You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. BCBSTX will give you a written decision within 60 days after it receives your request for review.

- If you have any questions about the claims procedures or the review procedure, write to BCBSTX's Administrative Office or call the toll-free Customer Service Helpline number shown in this Benefit Booklet or on your Identification Card.

- [If you have a claim for benefits which is denied or ignored, in whole or in part, and your Plan is governed by the Employee Retirement Income Security Act (ERISA), you may file suit under 502 (a) of ERISA.]

Preauthorization Appeal Procedures

If you or your Physician disagree with the determination of the preauthorization prior to or while receiving services, you may appeal that decision by contacting BCBSTX's Administrative Office.

In some instances, the resolution of the appeal process will not be completed until your inpatient admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter from BCBSTX, you may appeal that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

Claim Review Section
[Blue Cross and Blue Shield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044]

Once you have requested this review, you may submit additional information and comments on your claim to BCBSTX as long as you do so within 30 days of the date you ask for a review. Also, during this 30-day period, you may review any documents relevant to your claim held by BCBSTX, if you request an appointment in writing.

Within 30 days of receiving your request to review, BCBSTX, will send you its decision on the claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30-day period.

Interpretation of Employer's Plan Provisions

The operation and administration of the Plan require uniformity regarding the intent of the Plan and the interpretation of the Plan provisions. Your Employer has given BCBSTX full and complete authority and discretion to make decisions regarding the Plan provisions and determining questions of eligibility and benefits. Any decision by BCBSTX which is not arbitrary or capricious shall be final and conclusive, subject to any applicable Texas and federal law.

Actions Against BCBSTX

No lawsuit or action in law or equity may be brought by you or on your behalf prior to the expiration of 60 days after Proof of Loss has been filed in accordance with the requirement of the Plan and no such action will be brought at all unless brought within three years from the expiration of the time within which Proof of Loss is required by the Plan.

ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS

Eligible Expenses

The Plan provides coverage for four categories of Eligible Expenses:

- Inpatient Hospital Expenses,
- Medical-Surgical Expenses,
- Extended Care Expenses, and
- Special Provisions Expenses

Wherever Schedule of Coverage is mentioned, please refer to the Schedule(s) in this Benefit Booklet. Your benefits are calculated on a Calendar Year benefit period basis unless otherwise stated. At the end of a Calendar Year, a new benefit period starts for each Participant.

[Copayment Amounts

Some of the care and treatment you receive under the Plan will require that a Copayment Amount be paid at the time you receive the services. Refer to your Schedule of Coverage under "Copayment Amounts Required" for your specific Plan information.]

[A Copayment Amount will be required for each Physician office visit or consultation. If the services provided by your Physician require a return office visit (lab services for instance) on a different day, a new Copayment Amount will be required. [A Copayment Amount will be required for the initial office visit for Maternity Care, but will not be required for subsequent visits.]

The following services are not payable under this Copayment Amount provision but instead are considered Medical-Surgical Expense, subject to the [Deductible, if applicable, and] Coinsurance Amounts shown on your Schedule of Coverage:

- any services provided during the office visit or at the time of consultation (i.e., lab and x-ray services);
- surgery performed in the Physician's office;
- physical therapy billed separately from an office visit;
- occupational modalities in conjunction with physical therapy;
- allergy injections billed separately from an office visit;
- therapeutic injections;
- any services requiring preauthorization;
- Certain Diagnostic Procedures;
- [services provided by an Independent Lab, Imaging Center, radiologist, pathologist, and anesthesiologist;]
- [outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis.]]

[A Copayment Amount will be required for most Physician office visits, including lab and x-ray. If the services provided by your Physician require a return office visit (lab services for instance) on a different day, a new Copayment Amount will be required. [A Copayment Amount will be required for the initial office visit for Maternity Care, but will not be required for subsequent visits.]

The following services are not payable under this Copayment Amount provision but instead are considered Medical-Surgical Expense, subject to the Coinsurance Amounts [and may be subject to any Deductible] shown on your Schedule of Coverage:

- [surgery performed in the Physician's office;]
- [physical therapy billed separately from an office visit;]
- [occupational modalities in conjunction with physical therapy;]

- [allergy injections billed separately from an office visit;]
- [therapeutic injections;]
- [any services requiring preauthorization;]
- [Certain Diagnostic Procedures;]
- [services provided by an Independent Lab, Imaging Center, radiologist, pathologist, and anesthesiologist;]
- [outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis]]

[A Copayment Amount as indicated on your Schedule of Coverage will be required for each Physician office visit charge you incur when services are received by a family practitioner, an obstetrician/gynecologist, a pediatrician, an internist or a Professional Other Provider as described in the *Texas Insurance Code* and defined in the **DEFINITIONS** section of this Benefit Booklet.

A different Copayment Amount as indicated on your Schedule of Coverage will be required for each Physician office visit charge you incur when services are received by a Specialty Care Provider as classified by the American Board of Medical Specialist as a Specialty Care Provider.

The following services are not payable under this Copayment Amount provision but instead are considered Medical-Surgical Expense, subject to the Coinsurance Amounts [and may be subject to any Deductible]shown on your Schedule of Coverage:

- surgery performed in the Physician's office;
- [physical therapy billed separately from an office visit;]
- [occupational modalities in conjunction with physical therapy;]
- [allergy injections billed separately from an office visit;]
- [therapeutic injections;]
- any services requiring preauthorization;
- Certain Diagnostic Procedures;
- [services provided by an Independent Lab, Imaging Center, radiologist, pathologist, and anesthesiologist;]
- outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis.]

[A Copayment Amount, as indicated on your Schedule of Coverage, will be required for each visit to an Urgent Care center. If the services provided require a return visit (lab services for instance) on a different day, a new Copayment Amount will be required. The following services are not payable under this Copayment Amount provision but instead are considered Medical-Surgical Expense, subject to the [Deductible, if applicable, and] Coinsurance Amounts shown on your Schedule of Coverage:

- any services provided during the visit (i.e., lab and x-ray services);
- surgery performed in the center;
- physical therapy billed separately from an Urgent Care visit;
- occupational modalities in conjunction with physical therapy;
- allergy injections billed separately from an Urgent Care visit;
- therapeutic injections;
- any services requiring preauthorization;
- Certain Diagnostic Procedures;
- [services provided by an Independent Lab, Imaging Center, radiologist, pathologist, and anesthesiologist;]
- [outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis.]]

[A Copayment Amount will be required for each visit to an Urgent Care center[, including lab and x-ray]. If the services provided require a return visit (lab services for instance) on a different day, a new Copayment Amount

will be required. The following services are not payable under this Copayment Amount provision but instead are considered Medical-Surgical Expense, subject to the Coinsurance Amounts [and may be subject to any Deductible] shown on your Schedule of Coverage:

- [surgery performed in the Urgent Care center;]
- [physical therapy billed separately from an Urgent Care visit;]
- [occupational modalities in conjunction with physical therapy;]
- [allergy injections billed separately from an Urgent Care visit;]
- [therapeutic injections;]
- [any services requiring preauthorization;]
- [Certain Diagnostic Procedures;]
- [services provided by an Independent Lab, Imaging Center, radiologist, pathologist, and anesthesiologist;]
- [outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis]]

[A Copayment Amount will be required for facility charges for each Hospital outpatient emergency room visit. If admitted to the Hospital as a direct result of the emergency condition or accident, the Copayment Amount will be waived.]

[Deductibles

The benefits of the Plan will be available after satisfaction of the applicable Deductibles as shown on your Schedule of Coverage. The Deductibles will be increased in the future in direct proportion to the increase as determined from the cost-of-living adjustments based on the Consumer Price Index (CPI-U).

[The Deductibles are explained as follows:

1. If "Employee Only" is selected on your *Group Enrollment Application/Change Form*, the individual Deductible amount as shown on your Schedule of Coverage under "Deductibles," unless otherwise indicated, will apply to all combined Inpatient Hospital Expense, Medical-Surgical Expense, and Special Provisions Expense you incur during a Calendar Year and must be satisfied before any benefits are available under the Plan.

2. If "Family" coverage is selected on your *Group Enrollment Application/Change Form*, the family Deductible amount as shown on your Schedule of Coverage under "Deductibles," unless otherwise indicated, will apply to all combined Inpatient Hospital Expense, Medical-Surgical Expense, and Special Provisions Expense each Participant incurs during each Calendar Year and must be satisfied before any benefits are available under the Plan. The family Deductible amount may be satisfied by one Participant or a combination of two or more Participants.]

[Deductibles

The benefits of the Plan will be available after satisfaction of the applicable Deductibles as shown on your Schedule of Coverage. The Deductibles will be increased in the future in direct proportion to the increase as determined from the cost-of-living adjustments based on the Consumer Price Index (CPI-U).

The Deductibles are explained as follows:

1. The individual Deductible amount shown under "Deductibles" on your Schedule of Coverage must be satisfied by each Participant under your coverage each Calendar Year. This Deductible, unless otherwise indicated, will be applied to all categories of Eligible Expenses, before benefits are available under the Plan.

2. If you have several covered Dependents, all charges used to apply toward a "per individual" Deductible amount will be applied toward the "per family" Deductible amount shown on your Schedule of Coverage. When that family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Calendar Year. No Participant will contribute more than the individual Deductible amount to the "per family" Deductible amount.]

[Deductibles

The benefits of the Plan will be available after satisfaction of the applicable Deductibles as shown on your Schedule of Coverage. The Deductibles are explained as follows:

[**Per-admission Deductible**: The per-admission Deductible shown under "Deductibles" on your Schedule of Coverage will apply to **each** inpatient Hospital Admission of a Participant.]

[**Upfront Deductible**: The Upfront Deductible is a combined In and Out-of-Network annual Deductible that must be satisfied by each individual before any benefits under the plan are available. This Deductible will be applied to all categories of Eligible Expenses before certain benefits are available under the Plan.]

[**Calendar Year Deductible**: Upon satisfaction of the Upfront Deductible, each Participant will then be responsible for satisfying the combined In and Out-of-Network individual Calendar Year Deductible.]

[Until the Calendar Year Deductible is satisfied, benefits will be available only for those services or supplies subject to a Copayment Amount, such as Physician office visits, Emergency Room facility charges, and Covered Drugs under the Prescription Drug Program.]

[**Calendar Year Deductible**: The individual Deductible amount shown under "Deductibles" on your Schedule of Coverage must be satisfied by each Participant under your coverage each Calendar Year. This Deductible will be applied to all Medical-Surgical Expenses, Extended Care Expenses, and Special Provisions Expenses (unless otherwise indicated) before benefits are available under the Plan.]

[**Prescription Drug Deductible**: The Prescription Drug Deductible amount indicated on your Schedule of Coverage must be satisfied by each Participant each Calendar Year before Covered Drug benefits are available under the Plan. [This Prescription Drug Deductible is in addition to the individual Calendar Year Deductible amount.]]

[**Calendar Year Deductible**: The individual Deductible amount shown under "Deductibles" on your Schedule of Coverage must be satisfied by each Participant under your coverage each Calendar Year. This Deductible, unless otherwise indicated, will be applied to all categories of Eligible Expenses before benefits are available under the Plan.]

The following are exceptions to the Deductibles described above.

[Your Schedule of Coverage indicates "Three-Month Deductible Carryover applies." This means that any Eligible Expenses incurred during the last three months of a Calendar Year and applied toward satisfaction of the Calendar Year Deductible for that Calendar Year may be applied toward satisfaction of that Deductible for the following Calendar Year.]

[If you have several covered Dependents, all charges used to apply toward a "per individual" Deductible amount will be applied toward the "per family" Deductible amount shown on your Schedule of Coverage. When that family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Calendar Year. No Participant will contribute more than the individual Deductible amount to the "per family" Deductible amount.]

[If you have several covered Dependents, all charges used to apply toward a "per individual" Upfront Deductible amount will be applied toward the "per family" Upfront Deductible amount shown on your Schedule of Coverage. All charges used to apply toward a "per individual" Calendar Year Deductible amount will be applied toward the "per family" Calendar Year Deductible amount shown on your Schedule of Coverage. When the "per family" Calendar Year Deductible amount is met, no further individual Deductibles will have to be satisfied for the remainder of that Calendar Year. No Participant will contribute more than the individual Deductible amounts to the "per family" Deductible amounts.]

[Eligible Expenses applied toward satisfying the "per individual" Deductible will apply toward both the In-Network and the Out-of-Network Deductible amounts shown on your Schedule of Coverage. Eligible Expenses applied toward satisfying the "per family" Deductible will apply toward both the In-Network and the Out-of-Network Deductible amounts shown on your Schedule of Coverage.]

[Eligible Expenses applied toward satisfying the ["per individual"] [and] ["per family"] Out-of-Network Deductible will apply toward both the Out-of-Network and the In-Network Deductible. *However*, Eligible Expenses applied toward satisfying the ["per individual"] [and] ["per family"] In-Network Deductible **will not** apply toward satisfying the Out-of-Network Deductible.]

[Eligible Expenses applied toward satisfying the ["per individual"] [and] ["per family"] In-Network Deductible will only apply to the In-Network Deductible. Eligible Expenses applied toward satisfying the ["per individual"] [and] ["per family"] Out-of-Network Deductible will only apply to the Out-of-Network Deductible.]

[Out-of-Pocket Maximum

Most of your Eligible Expense payment obligations are applied to the Out-of-Pocket Maximum. The Out-of-Pocket Maximum will be increased in the future in direct proportion to the increase as determined from the cost-of-living adjustments based on the Consumer Price Index (CPI-U).

1. The Out-of-Pocket Maximum will not include:
   - Services, supplies, or charges limited or excluded by the Plan;
   - Expenses not covered because a benefit maximum has been reached;
   - Any Eligible Expense paid by the Primary Plan when BCBSTX is the Secondary Plan for purposes of coordination of benefits;
   - Penalties for failing to obtain preauthorization;
   - [Copayment Amounts;]
   - [Any Deductibles;]
   - [Any Copayment Amounts paid under the Prescription Drug Program;][.]
   - [Any remaining unpaid Medical-Surgical Expense in excess of the benefits provided for Covered Drugs if ["Outpatient Prescription Drug Expenses"] ["Prescription Drug Program"] is shown on your Schedule of Coverage.]

2. [If you selected "Employee Only" on your *Group Enrollment Application/Change Form*, when the "per individual" "Out of-Pocket Maximum" for a Calendar Year equals the amount shown on your Schedule of Coverage, the benefit percentage automatically increases to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by you during the remainder of that Calendar Year.

3. If you selected the "Family'' coverage on your *Group Enrollment Application/Change Form*, when the "per family" "Out-of-Pocket Maximum" for a Calendar Year equals the amount shown on your Schedule of coverage, the benefit percentage automatically increases to 100% for purposes of determining the benefits

available for additional Eligible Expenses incurred by all family Participants during the remainder of that Calendar Year. The family Out-of-Pocket Maximum may be satisfied by one or more covered Participants.]

[Out-of-Pocket Maximum

Most of your Eligible Expense payment obligations are applied to the Out-of-Pocket Maximum.[The Out-of-Pocket Maximum will be increased in the future in direct proportion to the increase as determined from the cost-of-living adjustments based on the Consumer Price Index (CPI-U).]

1. The Out-of-Pocket Maximum will not include:
   - Services, supplies, or charges limited or excluded by the Plan;
   - Expenses not covered because a benefit maximum has been reached;
   - Any Eligible Expense paid by the Primary Plan when BCBSTX is the Secondary Plan for purposes of coordination of benefits;
   - Penalties for failing to obtain preauthorization;
   - [Copayment Amounts;]
   - [Any Deductibles;]
   - [Any Copayment Amounts paid under the Prescription Drug Program;][.]
   - [Any remaining unpaid Medical-Surgical Expense in excess of the benefits provided for Covered Drugs if ["Outpatient Prescription Drug Expenses"] ["Prescription Drug Program"] is shown on your Schedule of Coverage.]

Individual Out-of-Pocket Maximum

When the Out-of-Pocket Maximum amount [for the In-Network or Out-of-Network Benefits level] for a Participant in a Calendar Year equals the "per individual" "Out-of-Pocket Maximum" shown on your Schedule of Coverage[for that level], the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by that Participant for the remainder of that Calendar Year[for that level].

Family Out-of-Pocket Maximum

When the Out-of-Pocket Maximum amount [for the In-Network or Out-of-Network Benefits level] for all Participants under your coverage in a Calendar Year equals the "per family" "Out-of-Pocket Maximum" shown on your Schedule of Coverage[for that level], the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by all family Participants for the remainder of that Calendar Year[for that level]. No Participant will be required to contribute more than the individual Out-of-Pocket Maximum to the family Out-of-Pocket Maximum.]

[The following are exceptions to the Out-of-Pocket Maximum described above:

[There are separate Out-of-Pocket Maximums for In-Network Benefits and Out-of-Network Benefits.]

[There are combined Out-of-Pocket Maximums for In-Network Benefits and Out-of-Network Benefits.]

[Eligible Expenses applied toward satisfying the "per individual" Out-of-Pocket Maximum will apply toward both the In-Network and the Out-of-Network Out-of-Pocket Maximum amounts shown on your Schedule of Coverage. Eligible Expenses applied toward satisfying the "per family" Out-of-Pocket Maximum will apply toward both the In-Network and the Out-of-Network Out-of-Pocket Maximum amounts shown on your Schedule of Coverage.]

[Eligible Expenses applied toward satisfying the ["per individual"] [and] ["per family"] Out-of-Network Out-of-Pocket Maximum will apply toward both the In-Network and Out-of-Network Out-of-Pocket Maximum amounts. *However*, Eligible Expenses applied toward satisfying the ["per individual"] [and] ["per family"] In-Network Out-of-Pocket Maximum amount **will not** apply toward satisfying the Out-of-Network Out-of Pocket Maximum amounts.]

[Eligible Expenses applied toward satisfying the ["per individual"] [and] ["per family"] In-Network Out-of-Pocket Maximum will only apply to the In-Network Out-of-Pocket Maximum. Eligible Expenses applied toward satisfying the ["per individual"] [and] ["per family"] Out-of-Network Out-of-Pocket Maximum will only apply to the Out-of-Network Out-of-Pocket Maximum.]]

[Copayment Amounts for In-Network Benefits and Out-of-Network Benefits will continue to be required after the benefit percentages become 100%.]

[Copayment Amounts for facility charges for outpatient Hospital emergency room visits for In-Network Benefits and Out-of-Network Benefits will continue to be required after the benefit percentages become 100%.]

[Copayment Amount for Urgent Care visits for In-Network Benefits will continue to be required after the benefit percentages become 100%.]

[Coinsurance Stop-Loss Amount

Most of your Eligible Expense payment obligations [including Copayment Amounts] are considered Coinsurance Amounts and are applied to the Coinsurance Stop-Loss Amount maximum.

Your Coinsurance Stop-Loss Amount will **not** include:

- Services, supplies, or charges limited or excluded by the Plan;
- Expenses not covered because a benefit maximum has been reached;
- Any Eligible Expenses paid by the Primary Plan when BCBSTX is the Secondary Plan for purposes of coordination of benefits;
- [Any Deductibles;]
- [Penalties applied for failure to preauthorize;]
- [Any Copayment Amounts paid under the Prescription Drug Program;][.]
- [Any remaining unpaid Medical-Surgical Expense in excess of the benefits provided for Covered Drugs if ["Outpatient Prescription Drug Expenses"] [Prescription Drug Program"] is shown on your Schedule of Coverage.]

Individual Coinsurance Stop-Loss Amount
When the Coinsurance Amount [for the In-Network or Out-of-Network Benefits level] for a Participant in a Calendar Year equals the "per individual" "Coinsurance Stop-Loss Amount" shown on your Schedule of Coverage [for that level], the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by that Participant for the remainder of that Calendar Year [for that level].

Family Coinsurance Stop-Loss Amount
When the Coinsurance Amount [for the In-Network or Out-of-Network Benefits level] for all Participants under your coverage in a Calendar Year equals the "per family" "Coinsurance Stop-Loss Amount" shown on your Schedule of Coverage [for that level], the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by all family Participants for the remainder of that Calendar Year [for that level]. No Participant will be required to contribute more than the individual Coinsurance Amount to the family Coinsurance Stop-Loss Amount.

[The following are exceptions to the Coinsurance Stop-Loss Amounts described above:

[There are separate Coinsurance Stop-Loss Amounts for In-Network Benefits and Out-of-Network Benefits.]

[There are combined Coinsurance Stop-Loss Amounts for In-Network Benefits and Out-of-Network Benefits.]

[Eligible Expenses applied toward satisfying the "per individual" Coinsurance Stop-Loss Amount maximum will apply toward both the In-Network and the Out-of-Network "Coinsurance Stop-Loss Amount" maximum shown on your Schedule of Coverage. Eligible Expenses applied toward satisfying the "per family" Coinsurance Stop-Loss Amount maximum will apply toward both the In-Network and the Out-of-Network "Coinsurance Stop-Loss Amount" maximum shown on your Schedule of Coverage.]

[Eligible Expenses applied toward satisfying the ["per individual"] [and] ["per family"] Out-of-Network Coinsurance Stop-Loss Amount maximum will apply toward both the In-Network and Out-of-Network Coinsurance Stop-Loss Amount. *However*, Eligible Expenses applied toward satisfying the ["per individual"] [and] ["per family"] In-Network Coinsurance Stop-Loss Amount maximum **will not** apply toward satisfying the Out-of-Network Coinsurance Stop-Loss Maximum amount.]

[Eligible Expenses applied toward satisfying the ["per individual"] [and] ["per family"] In-Network Coinsurance Stop-Loss Amount maximum will only apply to the In-Network Coinsurance Stop-Loss Amount maximum. Eligible Expenses applied toward satisfying the ["per individual"] [and] ["per family"] Out-of-Network Coinsurance Stop-Loss Amount maximum will only apply to the Out-of-Network Coinsurance Stop-Loss Amount maximum.]]

[Copayment Amounts for In-Network Benefits and Out-of-Network Benefits will continue to be required after the benefit percentages become 100%.]

[Copayment Amounts for facility charges for outpatient Hospital emergency room visits for In-Network Benefits and Out-of-Network Benefits will continue to be required after the benefit percentages become 100%.]

[Copayment Amount for Urgent Care visits for In-Network Benefits will continue to be required after the benefit percentages become 100%.]

[Annual Maximum Benefits

The total amount of benefits available to any one Participant for all combined categories of Eligible Expenses for a Calendar Year shall not exceed the "Annual Maximum Benefits" amount shown on your Schedule of Coverage. This Annual Maximum Benefit amount includes all payments made by BCBSTX under any benefit provision of the Plan.

At the end of a Calendar Year, a new benefit period starts for each Participant. Any unused amounts from the previous year do not accumulate. All totals from previous years do accumulate toward the Maximum Lifetime Benefits amount.]

Maximum Lifetime Benefits

The total amount of benefits available to any one Participant under the Plan shall not exceed the "Maximum Lifetime Benefits" amount shown on your Schedule of Coverage.

This Maximum Lifetime Benefits amount includes:

1. All payments made by BCBSTX under any benefit provisions of the Plan including payments toward any other benefit maximums under the Plan.

[2. All payments made by BCBSTX under the **[PRESCRIPTION DRUG PROGRAM][OUTPATIENT PRESCRIPTION DRUG EXPENSES]** portion of the Plan.]

Changes in Benefits

Changes to covered benefits will apply to all services provided to each Participant under the Plan. Benefits for Eligible Expenses incurred during an admission in a Hospital or Facility Other Provider that begins before the change will be those benefits in effect on the day of admission.

Inpatient Hospital Expenses

The Plan provides coverage for Inpatient Hospital Expense for you and eligible Dependents. Each inpatient Hospital Admission requires preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for additional information

The benefit percentage of your total eligible Inpatient Hospital Expense[, in excess of any Deductible,] shown under "Inpatient Hospital Expenses" on the Schedule of Coverage is BCBSTX's obligation under the Plan. The remaining unpaid Inpatient Hospital Expense[, in excess of any Deductible,] is your obligation to pay.

[Services and supplies provided by an Out-of-Network Provider will receive In-Network Benefits when those services and supplies are not available from a Network Provider provided BCBSTX acknowledges your visit to an Out-of-Network Provider **prior** to the visit. Otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjustment, if appropriate.]

Refer to the Schedule of Coverage for information regarding [Deductibles,] coinsurance percentages and penalties for failure to preauthorize that may apply to your coverage.

Medical-Surgical Expenses

The Plan provides coverage for Medical-Surgical Expense for you and your covered Dependents. Some services requires preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

[Copayment Amounts must be paid to your Network Physician or other Network Provider at the time you receive services.]

The benefit percentages of your total eligible Medical-Surgical Expense shown under "Medical-Surgical Expenses" on the Schedule of Coverage in excess of your [Copayment Amounts[,] [and] Coinsurance Amounts, [and any applicable Deductibles shown] are BCBSTX's obligation under the Plan. The remaining unpaid Medical-Surgical Expense in excess of the [Copayment Amount[,] [and] Coinsurance Amounts[,] [and any Deductibles] is your obligation to pay.

[To calculate your benefits, subtract any applicable Copayment Amounts [and Deductibles] from your total eligible Medical-Surgical Expense and then multiply the difference by the benefit percentage shown on your Schedule of Coverage under "Medical-Surgical Expenses." Most remaining unpaid Medical-Surgical Expense in excess of the Copayment Amount [and Deductible] is your Coinsurance Amount.]

[To calculate your benefits, multiply your total eligible Medical-Surgical Expense by the benefit percentage shown on your Schedule of Coverage under "Medical-Surgical Expenses." Most remaining unpaid Medical-Surgical Expense is your Coinsurance Amount.]

Medical-Surgical Expense shall include:

1. Services of Physicians and Professional Other Providers. If services are received from a Licensed Professional Counselor or Licensed Marriage and Family Therapist, a professional recommendation should be obtained from the Physician.

2. Consultation services of a Physician and Professional Other Provider.

3. Services of a certified registered nurse-anesthetist (CRNA).

4. Diagnostic x-ray and laboratory procedures.

5. Radiation therapy.

6. Dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.

7. Rental of durable medical equipment required for therapeutic use unless purchase of such equipment is required by BCBSTX. The term "durable medical equipment (DME)" shall not include:

   a. Equipment primarily designed for alleviation of pain or provision of patient comfort; or
   b. Home air fluidized bed therapy.

   Examples of non-covered equipment include, but are not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment, and whirlpool bath equipment.

   [All benefit payments made by BCBSTX for DME, whether under the In-Network or Out-of-Network Benefits level, will apply toward the benefit maximum under each level of benefits. However, any Diabetes Supplies considered DME will not apply toward this benefit maximum.]

8. Professional local ground ambulance service or air ambulance service to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition.

9. Anesthetics and its administration, when performed by someone other than the operating Physician or Professional Other Provider.

10. Oxygen and its administration provided the oxygen is actually used.

11. Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Participant.

12. Prosthetic Appliances, including replacements necessitated by growth to maturity of the Participant.

13. Orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including rigid back, leg or neck braces, casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets, Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint.

14. Home Infusion Therapy.

15. Services or supplies used by the Participant during an outpatient visit to a Hospital, a Therapeutic Center, or a Chemical Dependency Treatment Center, or scheduled services in the outpatient treatment room of a Hospital.

16. Certain Diagnostic Procedures.

17. [Outpatient Contraceptive Services, prescription contraceptive devices, and prescription contraceptive medications. NOTE: Prescription contraceptive medications are covered under the **[OUTPATIENT PRESCRIPTION DRUG EXPENSES] [PRESCRIPTION DRUG PROGRAM]** portion of your Plan.]

18. Telehealth Services and Telemedicine Medical Services.

19. Foot care in connection with an illness, disease, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes.

20. Injectable drugs, administered by or under the direction or supervision of a Physician or Professional Other Provider.

21. [Covered Drugs purchased for use outside of a Hospital. Refer to the **[PRESCRIPTION DRUG PROGRAM][OUTPATIENT PRESCRIPTION DRUG EXPENSES]** portion of this booklet for further information.]

Extended Care Expenses

The Plan also provides benefits for Extended Care Expense for you and your covered Dependents. All Extended Care Expense requires preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** section of this Benefit Booklet for more information.

BCBSTX's benefit obligation as shown on your Schedule of Coverage will be:

1. At the benefit percentage under "Extended Care Expenses," and

2. Up to the amount of the combined benefit maximum shown for each category of Extended Care Expense on your Schedule of Coverage.

[All payments made by BCBSTX, whether under the In-Network or Out-of-Network Benefit level, will apply toward the benefit maximum under both levels of benefits.]

[If shown on your Schedule of Coverage, the Calendar Year Deductible will apply.] Any unpaid Extended Care Expense in excess of the benefit maximums shown on your Schedule of Coverage will not be applied to any [Coinsurance Stop-Loss Amount] [Out-of-Pocket Maximums].

Any charges incurred as Home Health Care or home Hospice Care for drugs (including antibiotic therapy) and laboratory services will not be Extended Care Expense but will be considered Medical-Surgical Expense.

Services and supplies for Extended Care Expense:

1. For Skilled Nursing Facility:

    a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
    b. Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility;
    c. Physical, occupational, speech, and respiratory therapy services by licensed therapists.

2. For Home Health Care:

    a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
    b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
    c. Physical, occupational, speech, and respiratory therapy services by licensed therapists;
    d. Supplies and equipment routinely provided by the Home Health Agency.

    Benefits will **not** be provided for Home Health Care for the following:

    - Food or home delivered meals;
    - Social case work or homemaker services;
    - Services provided primarily for Custodial Care;
    - Transportation services;
    - Home Infusion Therapy;
    - Durable medical equipment.

3. For Hospice Care:

   For Home Hospice Care:

   a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
   b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
   c. Physical, speech, and respiratory therapy services by licensed therapists;
   d. Homemaker and counseling services routinely provided by the Hospice agency, including bereavement counseling.

   For Facility Hospice Care:

   a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
   b. Room and board and all routine services, supplies, and equipment provided by the Hospice facility;
   c. Physical, speech, and respiratory therapy services by licensed therapists.

Special Provisions Expenses

The benefits available under this **Special Provisions Expenses** subsection are generally determined on the same basis as other Inpatient Hospital Expense, Medical-Surgical Expense, and Extended Care Expense, except to the extent described in each item. Benefits for Medically Necessary expenses will be determined as indicated on your Schedule(s) of Coverage. Remember that certain services require preauthorization and that any [Copayment Amounts] [and] [Coinsurance Stop-Loss Amounts] [Out-of-Pocket Maximums] [and] [Deductibles] shown on your Schedule(s) of Coverage will also apply.

Benefits for Treatment of Complications of Pregnancy

Benefits for Eligible Expenses incurred for treatment of Complications of Pregnancy will be determined on the same basis as treatment for any other sickness.

Benefits for Maternity Care

Benefits for Eligible Expenses incurred for Maternity Care will be determined on the same basis as for any other treatment of sickness. Dependent children will [not] be eligible for Maternity Care benefits.

Services and supplies incurred by a Participant for delivery of a child shall be considered Maternity Care and are subject to all provisions of the Plan.

The Plan provides coverage for inpatient care for the mother and newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery; and
- 96 hours following an uncomplicated delivery by caesarean section.

If the mother or newborn is discharged before the minimum hours of coverage, the Plan provides coverage for *Postdelivery Care* for the mother and newborn. The *Postdelivery Care* may be provided at the mother's home, a health care Provider's office, or a health care facility.

Postdelivery Care means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. The term includes:

- parent education,
- assistance and training in breast-feeding and bottle feeding, and
- the performance of any necessary and appropriate clinical tests.

Charges for well-baby nursery care, including the initial examination, of a newborn child during the mother's Hospital Admission for the delivery will be considered Inpatient Hospital Expense of the child and will be subject to the benefit provisions and benefit maximums as described under **Inpatient Hospital Expenses**. [Benefits will also be subject to any Deductible amounts shown on your Schedule of Coverage.]

[***Benefits for In Vitro Fertilization Services***

Benefits for Medical-Surgical Expense incurred for in vitro fertilization services will be the same as for Maternity Care provided **all** of the following requirements are met:

a. The patient is a married Participant;

b. The fertilization or attempt at fertilization is made only with the sperm of the Participant's husband;

c. The Participant and her husband have a history of infertility of at least five continuous years duration or the infertility is associated with one or more of the following conditions:

- Endometriosis;
- Exposure in utero diethylstilbestrol (DES);
- Blockage or surgical removal of one or both fallopian tubes; or
- Oligospermia;

d. The Participant has been unable to obtain a successful pregnancy through any less costly applicable infertility treatment which is covered under the Plan; and

e. The in vitro fertilization procedures are performed in a facility licensed and approved to provide in vitro fertilization services under the appropriate state authority, if any.

No benefits for in vitro fertilization services are available if:

- Any condition contained in items (a) through (e) indicated above, is not complied with;
- The Employer has not applied for Maternity Care benefits;
- The services or supplies are for Inpatient Hospital Expense.]

Benefits for Treatment of Chemical Dependency

Benefits for Eligible Expenses incurred for the treatment of Chemical Dependency will be the same as for treatment of any other sickness. Your specific benefits are shown on your Schedule of Coverage. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection to determine what services require preauthorization.

Coverage for treatment of Chemical Dependency will be limited to a maximum of three separate series of treatments for each covered individual. The Plan may use state guidelines to administer benefits for treatment of Chemical Dependency. Inpatient treatment of Chemical Dependency must be provided in a Chemical Dependency Treatment Center. Benefits for the medical management of acute life-threatening intoxication (toxicity) in a Hospital will be available on the same basis as for sickness generally as described under **Benefits for Inpatient Hospital Expense**.

[All payments made by the Plan, whether under the In-Network or Out-of-Network Benefit level, will apply towards the "Maximum Lifetime Benefits" amount indicated on your Schedule of Coverage.]

Mental Health Care provided as part of the Medically Necessary treatment of Chemical Dependency will be considered for benefit purposes to be treatment of Chemical Dependency until completion of the series of Chemical Dependency treatments. (Mental Health Care treatment after completion of a series of Chemical Dependency treatments will be considered Mental Health Care.)

Benefits for Serious Mental Illness

Benefits for Eligible Expenses incurred for the treatment of Serious Mental Illness are shown on your Schedule of Coverage. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection to determine what services require preauthorization.

Medically Necessary services for Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents in lieu of hospitalization will be considered Inpatient Hospital Expense. The Inpatient Hospital Expense benefit percentages for this Plan[, and any Deductible] as shown on your Schedule of Coverage, will apply. [Each full day of treatment in such facility will be considered equal to one-half of one day of a regular Hospital Admission for Serious Mental Illness.]

[Inpatient Hospital Expense for Serious Mental Illness will be limited to the number of inpatient days per Calendar Year shown on your Schedule of Coverage.

Medical-Surgical Expense incurred for Serious Mental Illness will be limited to the number of inpatient Physician and/or Professional Other Provider visits per Calendar Year shown on your Schedule of Coverage.

Benefits for Medical-Surgical Expense incurred for Serious Mental Illness will be limited to the combined number of outpatient Physician and/or Professional Other Provider or other outpatient visits per Calendar Year.]

[All inpatient benefits used, including Hospital days and Physician/Professional Other Provider visits, whether In-Network or Out-of-Network, apply to inpatient days or visits shown on the Schedule of Coverage for each level of benefits.

All outpatient Physician and/or Professional Other Provider and other outpatient visit benefits used, whether In-Network or Out-of-Network, apply to outpatient visits shown on the Schedule of Coverage for each level of benefits.]

The benefits provided for Serious Mental Illness will not exceed the "Maximum Lifetime Benefits" amount shown on your Schedule of Coverage.

[Benefits for Mental Health Care

Benefits for Eligible Expenses incurred for the treatment of Mental Health Care are shown on your Schedule of Coverage. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection to determine what services require preauthorization.

Medically Necessary services for Mental Health Care in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents in lieu of hospitalization will be considered Inpatient Hospital Expense. The Inpatient Hospital Expense benefit percentages for this Plan[, and any Deductible] as shown on your Schedule of Coverage, will apply. Each full day of treatment in such facility will be considered equal to one-half of one day of a regular Hospital Admission for Mental Health Care.

Inpatient Hospital Expense for Mental Health Care will be limited to the number of inpatient days per Calendar Year shown on your Schedule of Coverage.

Medical-Surgical Expense incurred for Mental Health Care will be limited to the number of inpatient Physician and/or Professional Other Provider visits per Calendar Year shown on your Schedule of Coverage.

Benefits for Medical-Surgical Expense incurred for Mental Health Care will be limited to the combined number of outpatient Physician and/or Professional Other Provider or other outpatient visits per Calendar Year.

[All inpatient benefits used, including Hospital days and Physician/Professional Other Provider visits, whether In-Network or Out-of-Network, apply to inpatient days or visits shown on the Schedule of Coverage for each level of benefits.

All outpatient Physician and/or Professional Other Provider and other outpatient visit benefits used, whether In-Network or Out-of-Network, apply to outpatient visits shown on the Schedule of Coverage for each level of benefits.]

The benefits provided for Mental Health Care will not exceed the "Maximum Lifetime Benefits" amount shown on your Schedule of Coverage.

Benefits for Emergency Care and Treatment of Accidental Injury

The Plan provides coverage for medical emergencies wherever they occur. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

[Benefits for Eligible Expenses for Accidental Injury or Emergency Care will be determined on the same basis as for treatment of any other sickness. If admitted for the emergency condition as a direct result of the outpatient Hospital emergency room visit, preauthorization of the inpatient Hospital admission will be required.]

[If reasonably possible, contact your Network Physician before going to the Hospital emergency room. He can help you determine if you need Emergency Care or treatment of an Accidental Injury and recommend that care. If not reasonably possible, go to the nearest emergency facility, whether or not the facility is in the Network.

Whether you require hospitalization or not, you should notify your Network Physician within 48 hours, or as soon as reasonably possible, of any emergency medical treatment so he can recommend the continuation of any necessary medical services.

In-Network and Out-of-Network Benefits for Eligible Expenses for Accidental Injury or Emergency Care will be determined as shown on your Schedule of Coverage. [Copayment Amounts will be required for facility charges for each outpatient Hospital emergency room visit as indicated on your Schedule of Coverage. If admitted for the emergency condition immediately following the visit, the Copayment Amount will be waived.] If admitted for the emergency condition immediately following the visit, preauthorization of the inpatient Hospital Admission will be required.

All treatment received during the first 48 hours following the onset of a medical emergency will be eligible for In-Network Benefits. After 48 hours, In-Network Benefits will be available only if you use Network Providers. If after the first 48 hours of treatment following the onset of a medical emergency, and if you can safely be transferred to the care of a Network Provider but are treated by an Out-of-Network Provider, only Out-of-Network Benefits will be available.]

[Benefits for Urgent Care

Benefits for Eligible Expenses for Urgent Care will be determined as shown on your Schedule of Coverage. [A Copayment Amount, in the amount indicated on your Schedule of Coverage, will be required for each Urgent Care visit.] Urgent Care means the delivery of medical care in a facility dedicated to the delivery of scheduled or unscheduled, walk-in care outside of a hospital emergency room department or physician's office. The necessary medical care is for a condition that is not life-threatening.]

Benefits for Preventive Care

Benefits for Medical-Surgical Expense are available for the following preventive care services as indicated on your Schedule of Coverage:

- well-baby care (after newborn's initial examination and discharge from the Hospital);
- routine annual physical examination;
- [annual vision examination;]
- annual hearing examination, except for benefits as provided under ***Required Benefits for Screening Tests for Hearing Impairment***;
- immunizations for Participants age six and over.

Benefits for childhood immunizations will be provided as described in ***Required Benefits for Childhood Immunizations*** for children under the age of six. Benefits are not available for Inpatient Hospital Expense or Medical-Surgical Expense for routine physical examinations performed on an inpatient basis, except for the initial examination of a newborn child.

[Benefits for preventive care services will be calculated at the benefit percentage shown on your Schedule of Coverage for the services listed above up to the maximum benefit amount shown under "Preventive Care." This maximum benefit amount is for the indicated period of time which starts on the first day an Eligible Expense is incurred. After that period of time has elapsed, a new maximum benefit amount begins again. The benefit period and maximum benefit amount are applicable to each Participant individually.]

Injections for allergies are not considered immunizations under this benefit provision.

Benefits for Mammography Screening

If a Participant [35 years of age and older] incurs Medical-Surgical Expense for a screening by low-dose mammography for the presence of occult breast cancer, benefits will be determined on the same basis as for other Medical-Surgical Expense as shown on your Schedule of Coverage, except that benefits will not be available for more than one routine mammography screening each Calendar Year.

Benefits for Detection and Prevention of Osteoporosis

If a Participant is a *Qualified Individual*, Medical-Surgical Expense benefits will be determined on the same basis as any other sickness for medically accepted bone mass measurement for the detection of low bone mass and to determine a Participant's risk of osteoporosis and fractures associated with osteoporosis.

Qualified Individual means:

a. A postmenopausal woman not receiving estrogen replacement therapy;

b. An individual with:
   - vertebral abnormalities,
   - primary hyperparathyroidism, or
   - a history of bone fractures; or

c. An individual who is:
   - receiving long-term glucocorticoid therapy, or
   - being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Benefits for Tests for Detection of Colorectal Cancer

Benefits for Medical-Surgical Expense incurred for a diagnostic, medically recognized screening examination for the detection of colorectal cancer, for Participants [who are 50 years of age or older and] who are at normal risk for developing colon cancer, will be determined on the same basis as any other sickness for:

- A fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years; or
- A colonoscopy performed every ten years.

Benefits for Certain Tests for Detection of Prostate Cancer

If a male Participant incurs Medical-Surgical Expense for diagnostic medical procedures incurred in conducting an annual medically recognized diagnostic examination for the detection of prostate cancer, benefits will be provided only for a:

a. physical examination for the detection of prostate cancer; and

b. prostate-specific antigen test used for the detection of prostate cancer for each male under the Plan [who is at least:

(1) 50 years of age and asymptomatic; or

(2) 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.]

Benefits for Speech and Hearing Services

Benefits as shown on your Schedule of Coverage are available for the services of a Physician or Professional Other Provider to restore loss of or correct an impaired speech or hearing function.

[Any benefit payments made by BCBSTX for hearing aids, whether under the In-Network Benefits or Out-of-Network Benefits level, will apply toward the benefit maximum amount indicated on the Schedule of Coverage for each level of benefits.

[Any benefit payments made by BCBSTX for hearing aids will apply toward the benefit maximum amount indicated on the Schedule of Coverage.]

Benefits for Certain Tests for Detection of Human Papillomavirus and Cervical Cancer

Benefits will be determined on the same basis as for other Medical-Surgical Expenses as shown on your Schedule of Coverage, for each woman enrolled in the Plan who is 18 years of age or older, for Eligible Expenses incurred for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage includes, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods as approved by the United States Food and Drug Administration alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

Required Benefits for Childhood Immunizations

Benefits for Medical-Surgical Expense incurred by a Dependent child for childhood immunizations from birth through the date the child turns six years of age will be determined at 100% of the Allowable Amount. [Deductibles,] [and] [Copayment Amounts,] [and] Coinsurance Amounts will not be applicable.

Benefits are available for:

- Diphtheria,
- Hemophilus influenza type b,
- Hepatitis B,
- Measles,
- Mumps,
- Pertussis,
- Polio,
- Rubella,
- Tetanus,
- Varicella, and
- Any other immunization that is required by law for the child.

Injections for allergies are not considered immunizations under this benefit provision.

Benefits for Certain Therapies for Children with Developmental Delays

Medical-Surgical Expense benefits are available to a covered Dependent child for the necessary rehabilitative and habilitative therapies in accordance with an Individualized Family Service Plan issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73, *Texas Human Resources Code.*

Such therapies include:

- occupational therapy evaluations and services;
- physical therapy evaluations and services;
- speech therapy evaluations and services; and
- dietary or nutritional evaluations

The *Individualized Family Service Plan* must be submitted to BCBSTX prior to the commencement of services and when the Individualized Family Service Plan is altered.

After the age of 3, when services under the *Individualized Family Service Plan* are completed, Eligible Expenses, as otherwise covered under this Plan, will be available. All contractual provisions of this Plan will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.

Developmental Delay means a significant variation in normal development as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas:

- Cognitive development;
- Physical development;
- Communication development;
- Social or emotional development; or
- Adaptive development.

Individualized Family Service Plan means an initial and ongoing treatment plan developed by the Texas Interagency Council on Early Childhood Intervention.

Required Benefits for Screening Tests for Hearing Impairment

Benefits are available for Eligible Expenses incurred by a covered Dependent child:

- For a screening test for hearing loss from birth through the date the child is 30 days old; and
- Necessary diagnostic follow-up care related to the screening tests from birth through the date the child is 24 months.

[Deductibles indicated on your Schedule of Coverage will not apply to this provision.]

Benefits for Cosmetic, Reconstructive, or Plastic Surgery

The following Eligible Expenses described below for Cosmetic, Reconstructive, or Plastic Surgery will be the same as for treatment of any other sickness as shown on your Schedule of Coverage:

- Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant; or
- Treatment provided for reconstructive surgery following cancer surgery; or
- Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
- Surgery performed on a covered Dependent child (other than a newborn child) [under the age of 19] for the treatment or correction of a congenital defect other than conditions of the breast; or
- Reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy; or
- Reconstructive surgery performed on a covered Dependent child [under the age of 19] due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Benefits for Dental Services

Benefits for Eligible Expenses incurred by a Participant will be provided on the same basis as for treatment of any other sickness as shown on the Schedule of Coverage only for the following.

- Covered Oral Surgery;
- Services provided to a newborn child which are necessary for treatment or correction of a congenital defect; or
- The correction of damage caused solely by external, violent Accidental Injury to healthy, un-restored natural teeth and supporting tissues, limited to treatment provided within 24 months of the initial treatment. An injury sustained as a result of biting or chewing shall not be considered an Accidental Injury.

Any other dental services, except as excluded in the **MEDICAL LIMITATIONS AND EXCLUSIONS** section of this Benefit Booklet, for which a Participant incurs Inpatient Hospital Expense for a Medically Necessary inpatient Hospital Admission, will be determined as described in **Benefits for Inpatient Hospital Expenses**.

Benefits for Organ and Tissue Transplants

a. Subject to the conditions described below, benefits for covered services and supplies provided to a Participant by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met:

   (1) The transplant procedure is not Experimental/Investigational in nature; and
   (2) Donated human organs or tissue or an FDA-approved artificial device are used; and
   (3) The recipient is a Participant under the Plan; and
   (4) The transplant procedure is preauthorized as required under the Plan; and
   (5) The Participant meets all of the criteria established by BCBSTX in pertinent written medical policies; and
   (6) The Participant meets all of the protocols established by the Hospital in which the transplant is performed.

   Covered services and supplies "related to" an organ or tissue transplant include, but are not limited to, x-rays, laboratory testing, chemotherapy, radiation therapy, prescription drugs, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.

b. Benefits are available and will be determined on the same basis as any other sickness when the transplant procedure is considered Medically Necessary and meets all of the conditions cited above.

   Benefits will be available for:

   (1) A recipient who is covered under this Plan; and
   (2) A donor who is a Participant under this Plan; or
   (3) A donor who is not a Participant under this Plan.

   Benefits for the recipient and the donor will be provided up to the recipient's "Maximum Lifetime Benefits" amount shown on the Schedule of Coverage. Once the lifetime maximum amount has been exhausted, no further benefits will be available under the Plan.

c. Covered services and supplies include services and supplies provided for the:

   (1) Evaluation of organs or tissues including, but not limited to, the determination of tissue matches; and
   (2) Removal of organs or tissues from living or deceased donors; and
   (3) Transportation and short-term storage of donated organs or tissues.

d. No benefits are available for a Participant for the following services or supplies:

   (1) Living and/or travel expenses of the recipient or a live donor;
   (2) Donor search and acceptability testing of potential live donors;
   (3) Expenses related to maintenance of life of a donor for purposes of organ or tissue donation;
   (4) Purchase of the organ or tissue; or
   (5) Organs or tissue (xenograft) obtained from another species.

e. Preauthorization is required for any organ or tissue transplant. Review the **PREAUTHORIZATION REQUIREMENTS** section in this Benefit Booklet for more specific information about preauthorization.

   (1) Such specific preauthorization is required even if the patient is already a patient in a Hospital under another preauthorization authorization.

(2) At the time of preauthorization, BCBSTX will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if BCBSTX determines that an extension is Medically Necessary.

f. No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which BCBSTX considers to be Experimental/ Investigational.

Benefits for Treatment of Acquired Brain Injury

Benefits for Eligible Expenses incurred for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Eligible Expenses include the following *services* as a result of and related to an Acquired Brain Injury:

a. Cognitive communication therapy - *Services* designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information;

b. Cognitive rehabilitation therapy - *Services* designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits;

c. Community reintegration services - *Services* that facilitate the continuum of care as an affected individual transitions into the community;

d. Neurobehavioral testing - An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others;

e. Neurobehavioral treatment - Interventions that focus on behavior and the variables that control behavior;

f. Neurocognitive rehabilitation - *Services* designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques;

g. Neurocognitive therapy – *Services* designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities;

h. Neurofeedback therapy - *Services* that utilizes operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood;

i. Neurophysiological testing - An evaluation of the functions of the nervous system;

j. Neurophysiological treatment – Interventions that focus on the functions of the nervous system;

k. Neuropsychological testing – The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning;

l. Neuropsychological treatment – Interventions designed to improve or minimize deficits in behavioral and cognitive processes;

m. Post-acute transition services - *Services* that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration;

n. Psychophysiological testing - An evaluation of the interrelationships between the nervous system and other bodily organs and behavior;

o. Psychophysiological treatment – Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors;

p. Remediation - The process(es) of restoring or improving a specific function.

Service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury.

Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury.

Benefits for Treatment of Diabetes

Benefits are available and will be determined on the same basis as any other sickness for those Medically Necessary items for *Diabetes Equipment* and *Diabetes Supplies* (for which a Physician or Professional Other Provider has written an order) and *Diabetic Management Services/Diabetes Self-Management Training*. Such items, when obtained for a *Qualified Participant,* shall include but not be limited to the following:

a. *Diabetes Equipment*

(1) [Blood glucose monitors (including noninvasive glucose monitors and monitors for the blind);]

(2) Insulin pumps (both external and implantable) and associated appurtenances, which include:

- Insulin infusion devices,
- Batteries,
- Skin preparation items,
- Adhesive supplies,
- Infusion sets,
- Insulin cartridges,
- Durable and disposable devices to assist in the injection of insulin, and
- Other required disposable supplies; and

(3) Podiatric appliances, including up to two pairs of therapeutic footwear per Calendar Year, for the prevention of complications associated with diabetes.

b. *Diabetes Supplies*

(1) [Test strips specified for use with a corresponding blood glucose monitor]

(2) [Lancets and lancet devices]

(3) [Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein]

(4) [Insulin and insulin analog preparations]

(5) [Injection aids, including devices used to assist with insulin injection and needleless systems]

(6) [Insulin syringes]

(7) [Biohazard disposable containers]

(8) [Prescriptive and non-prescriptive oral agents for controlling blood sugar levels,] [and]

(9) [Glucagon emergency kits]

[NOTE: [*Insulin and insulin analog preparations], [insulin syringes necessary for self-administration,] [prescriptive and non-prescriptive oral agents] will be covered under the Outpatient Prescription Drug Expenses benefit.*]

[NOTE: *All Diabetes Supplies listed in item b above will be covered under the Outpatient Prescription Drug Expenses benefit portion of your plan* [*along with blood glucose monitors (including noninvasive glucose monitors and monitors for the blind)*].]

[NOTE: [*Insulin and insulin analog preparations], [insulin syringes necessary for self-administration,] [prescriptive and non-prescriptive oral agents] [along with [all required test strips], [tablets for glucose, ketones, and protein], [lancets and lancet devices,] [biohazard disposable containers,] [glucagon emergency kits,] [and] [other injection aids]] will be covered under the Prescription Drug Program]*.

[NOTE: *All Diabetes Supplies listed in item b above will be covered under the Prescription Drug Program portion of your plan* [*along with blood glucose monitors (including noninvasive glucose monitors and monitors for the blind)*].]

c. Repairs and necessary maintenance of insulin pumps not otherwise provided for under the manufacturer's warranty or purchase agreement, rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.

d. As new or improved treatment and monitoring equipment or supplies become available and are approved by the U. S. Food and Drug Administration (FDA), such equipment or supplies may be covered if determined to be Medically Necessary and appropriate by the treating Physician or Professional Other Provider who issues the written order for the supplies or equipment.

e. Medical-Surgical Expense provided for the nutritional, educational, and psychosocial treatment of the *Qualified Participant*. Such *Diabetic Management Services/Diabetes Self-Management Training* for which a Physician or Professional Other Provider has written an order to the Participant or caretaker of the Participant is limited to the following when rendered by or under the direction of a Physician.

   Initial and follow-up instruction concerning:

   (1) The physical cause and process of diabetes;

   (2) Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;

   (3) Prevention and treatment of special health problems for the diabetic patient;

   (4) Adjustment to lifestyle modifications; and

   (5) Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

Diabetes Self-Management Training for the *Qualified Participant* will include the development of an individualized management plan that is created for and in collaboration with the *Qualified Participant* (and/or his or her family) to understand the care and management of diabetes, including nutritional counseling and proper use of *Diabetes Equipment* and *Diabetes Supplies.*

A *Qualified Participant* means an individual eligible for coverage under this Contract who has been diagnosed with (a) insulin dependent or non-insulin dependent diabetes, (b) elevated blood glucose levels induced by pregnancy, or (c) another medical condition associated with elevated blood glucose levels.

Benefits for Physical Medicine Services

Benefits for Medical-Surgical Expense incurred for Physical Medicine Services are available as shown on your Schedule of Coverage.

[All benefit payments made by BCBSTX for Physical Medicine Services, whether under the In-Network or Out-of-Network Benefits level, will apply toward the benefit maximum under each level of benefits.]

MEDICAL LIMITATIONS AND EXCLUSIONS

The benefits as described in this Benefit Booklet are not available for:

1. Any services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.

2. Any Experimental/Investigational services and supplies.

3. Any portion of a charge for a service or supply that is in excess of the Allowable Amount as determined by BCBSTX.

4. Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.

5. Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

6. Any services or supplies for which a Participant is not required to make payment or for which a Participant would have no legal obligation to pay in the absence of this or any similar coverage, except services or supplies for treatment of mental illness or mental retardation provided by a tax supported institution of the State of Texas.

7. Any services or supplies provided by a person who is related to the Participant by blood or marriage.

8. Any services or supplies provided for injuries sustained:

    - As a result of war, declared or undeclared, or any act of war; or
    - While on active or reserve duty in the armed forces of any country or international authority.

9. Any charges:

    - Resulting from the failure to keep a scheduled visit with a Physician or Professional Other Provider; or
    - For completion of any insurance forms; or
    - For acquisition of medical records.

10. Room and board charges incurred during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the Participant's physical condition or the quality of medical care provided.

11. Any services or supplies provided before the patient is covered as a Participant hereunder or any services or supplies provided after the termination of the Participant's coverage, except as provided in ***Extension Of Benefits***.

12. Any services or supplies provided for Dietary and Nutritional Services, except as may be provided under the Plan for:

    - an inpatient nutritional assessment program provided in and by a Hospital and approved by BCBSTX; or
    - ***Benefits for Treatment of Diabetes*** as described in **Special Provisions Expenses**; or

- ***Benefits for Certain Therapies for Children with Developmental Delays*** as described in **Special Provisions Expenses.**

13. Any services or supplies provided for Custodial Care.

14. Any non-surgical (dental restorations, orthodontics, or physical therapy) or non-diagnostic services or supplies (oral appliances, oral splints, oral orthotics, devices, or prosthetics) provided for the treatment of the temporomandibular joint (including the jaw and craniomandibular joint) and all adjacent or related muscles.

15. Any services or supplies provided for orthognathic surgery after the Participant's 19th birthday, (except orthognathic surgery for treatment of temporomandibular joint disorders and conditions of temporomandibular joint disorders as described in the exclusion above, are covered). Orthognathic surgery includes, but is not limited to, correction of congenital, developmental, or acquired maxillofacial skeletal deformities of the mandible and maxilla.

16. [Any items of Medical-Surgical Expense incurred for dental care and treatments, [Covered Oral Surgery,][dental surgery,] or dental appliances, except as provided for in the ***Benefits for Dental Services*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.]

17. Any services or supplies provided for Cosmetic, Reconstructive, or Plastic Surgery, except as provided for in the ***Benefits for Cosmetic, Reconstructive, or Plastic Surgery*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.

18. Any services or supplies provided for:

    - [Treatment of myopia and other errors of refraction, including refractive surgery; or]
    - Orthoptics or visual training; or
    - Eyeglasses or contact lenses, provided that intraocular lenses shall be specific exceptions to this exclusion; or
    - Examinations for the prescription or fitting of eyeglasses or contact lenses, except as may be provided under the ***Benefits for Preventive Care*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet; or
    - Restoration of loss or correction to an impaired speech or hearing function, including hearing aids, except as may be provided under the ***Benefits for Speech and Hearing Services*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.

19. [Except as specifically included as an Eligible Expense, [any Medical Social Services,] [any outpatient family counseling] [and/or] [therapy,] [bereavement counseling,] [vocational counseling,] or [Marriage and Family Therapy and/or counseling].]

20. [Any services or supplies provided for treatment of adolescent behavior disorders, including conduct disorders and opposition disorders.]

21. [Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function.]

22. Travel or ambulance services because it is more convenient for the patient than other modes of transportation whether or not recommended by a Physician or Professional Other Provider.

23. Any services or supplies provided primarily for:

    - Environmental Sensitivity;
    - Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or
    - Inpatient allergy testing or treatment.

24. [Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.]

25. [Any services or supplies provided for, in preparation for, or in conjunction with:]

    - [Sterilization reversal (male or female);]
    - Transsexual surgery;
    - [Sexual dysfunctions;]
    - [In vitro fertilization;] [and]
    - [Promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, trans-uterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.]

26. [Any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, the cutting and trimming of toenails, or foot care for flat feet, fallen arches, and chronic foot strain in the absence of severe systemic disease.]

27. [Any prescription [antiseptic or fluoride mouthwashes,] [mouth rinses,] [or] [topical oral solutions] [or] [preparations].]

28. [Services or supplies for [smoking cessation programs [and]] [the treatment of nicotine addiction].]

29. [Any services or supplies provided for the following treatment modalities:]

    - [acupuncture;]
    - [video fluoroscopy;]
    - [intersegmental traction;]
    - [surface EMGs;]
    - [manipulation under anesthesia;] [and]
    - [muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.]

30. [Benefits for any covered services or supplies furnished by a Contracting Facility for which such facility has not been specifically approved to furnish under a written contract or agreement with BCBSTX will be paid at the Out-of-Network benefit level.]

31. Any items that include, but are not limited to, [an orthodontic] [or] [other dental appliance;] [splints or bandages provided by a Physician in a non-hospital setting or purchased “over the counter” for support of strains and sprains;] [orthopedic shoes which are a separable part of a covered brace,] [specially ordered,] [custom-made] [or] [built-up shoes,] [cast shoes,] [shoe inserts designed to support the arch or affect changes in the foot or foot alignment,] [arch supports,] [elastic stockings] [and] [garter belts].

    NOTE: This exclusion does not apply to podiatric appliances when provided as Diabetic Equipment.

32. Any benefits in excess of any specified dollar, day/visit, Calendar Year, or lifetime maximums.

33. Any services and supplies provided to a Participant incurred outside the United States if the Participant traveled to the location for the purposes of receiving medical services, supplies, or drugs.

34. [Donor expenses for a Participant in connection with an organ and tissue transplant if the recipient is not covered under this Plan.]

35. [Replacement Prosthetic Appliances except those necessitated by growth due to maturity of the Participant.]

36. [Private duty nursing services, except for covered Extended Care Expense.]

37. [Any Covered Drugs for which benefits are available under the [Prescription Drug Program][Outpatient Prescription Drug Expense] portion of the Plan.]

38. [Any drugs and medicines purchased for use outside a Hospital which require a written prescription for purchase other than injectable drugs administered by or under the direct supervision of a Physician or Professional Other Provider.]

39. [Any Outpatient Contraceptive Services, contraceptive drugs, and devices.]

[39.Any Outpatient Contraceptive Services, contraceptive drugs, and devices, unless the prescription contraceptive coverage is necessary to preserve the life or health of the Participant. In the event Outpatient Contraceptive Services are covered under the Plan, contraceptive prescription drugs may be covered under the [Prescription Drug Program][Outpatient Prescription Drug Expense] portion of your Plan.]

40. [Any services or supplies for Mental Health Care.]

41. [Any services or supplies provided for reduction mammoplasty.]

42. [Any services or supplies provided for reduction of obesity or weight, including surgical procedures, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight.]

43. Any services or supplies not specifically defined as Eligible Expenses in this Plan.

DEFINITIONS

The definitions used in this Benefit Booklet apply to all coverage unless otherwise indicated.

Accidental Injury means accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a Physician or Professional Other Provider.

Acquired Brain Injury means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Allowable Amount means the maximum amount determined by BCBSTX to be eligible for consideration of payment for a particular service, supply, or procedure.

- ***For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers contracting with BCBSTX in Texas or any other Blue Cross and Blue Shield Plan*** – The Allowable Amount is based on the terms of the Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.

- ***For Hospitals and Facility Other Providers not contracting with BCBSTX in Texas or any other Blue Cross and Blue Shield Plan outside of Texas –*** The Allowable Amount will be the amount BCBSTX would have considered for payment for the same procedure, service, or supply at an equivalent contracting Hospital or Facility Other Provider, using Texas regional or state fee schedules or rate and payment methodologies. For Hospitals or Facility Other Providers where fee schedules or rate payments are not appropriate, the Allowable Amount will be the lesser of billed charge or a per diem established by BCBSTX.

- ***For procedures, services, or supplies provided in Texas by Physicians and Professional Other Providers not contracting with BCBSTX*** – The Allowable Amount will be the lesser of the billed charge or the amount BCBSTX would have considered for payment for the same covered procedure, service, or supply if performed or provided by a Physician or Professional Other Provider with similar experience and/or skill.

  If BCBSTX does not have sufficient data to calculate the Allowable Amount for a particular procedure, service, or supply, BCBSTX will determine an Allowable Amount based on the complexity of the procedure, service, or supply and any unusual circumstances or medical complications specifically brought to its attention, which require additional experience, skill, and/or time.

7. ***For procedures, services, or supplies performed outside of Texas by Physicians or Professional Other Providers not contracting with BCBSTX or any other Blue Cross and Blue Shield Plan*** – BCBSTX will establish an Allowable Amount using Texas regional or state allowable amounts applicable to procedures, services, or supplies of Physicians or Professional Other Providers with similar skills and experience.

8. ***For multiple surgeries*** – The Allowable Amount for all surgical procedures performed on the same patient on the *same* day will be the amount for the single procedure with the highest Allowable Amount *plus* one-half of the Allowable Amount *for each* of the other covered procedures performed.

9. ***For drugs administered by a Home Infusion Therapy Provider –*** The Allowable Amount will be the lesser of: (1) the actual charge, or (2) the Average Wholesale Price (AWP) plus a predetermined percentage mark-up or mark-down from the AWP established by BCBSTX and updated on a periodic basis.

10. ***For procedures, services, or supplies provided to Medicare recipient****s* – The Allowable Amount will not exceed Medicare's limiting charge.

11. ***[For Covered Drugs as applied to Participating and Non-Participating Pharmacies*** – The Allowable Amount for Participating Pharmacies [and the Mail Service Prescription Drug Program] will be based on the

provisions of the contract between BCBSTX and the Participating Pharmacy [or Pharmacy for the Mail Service Prescription Drug Program] in effect on the date of service. The Allowable Amount for Non-Participating Pharmacies will be based on the Average Wholesale Price.]

Average Wholesale Price means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a Pharmacy.

Calendar Year means the period commencing on a January 1 and ending on the next succeeding December 31, inclusive.

Certain Diagnostic Procedures means:

- Bone Scan
- Cardiac Stress Test
- CT Scan (with or without contrast)
- MRI (Magnetic Resonance Imaging)
- Myelogram
- PET Scan (Positron Emission Tomography)
- Ultrasound

Chemical Dependency means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

Chemical Dependency Treatment Center means a facility which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician and which facility is also:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
2. Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or
3. Licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
4. Licensed, certified, or approved as a chemical dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

Clinical Ecology means the inpatient or outpatient diagnosis or treatment of allergic symptoms by:

1. Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells);
2. Urine auto injection (injecting one's own urine into the tissue of the body);
3. Skin irritation by Rinkel method;
4. Subcutaneous provocative and neutralization testing (injecting the patient with allergen); or
5. Sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

Coinsurance Amount means the dollar amount expressed as a percentage of Eligible Expenses incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan.

[Coinsurance Stop-Loss Amount means the cumulative dollar amount of most Eligible Expenses incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan.]

Complications of Pregnancy means:

1. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but *shall not include* false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy, and

2. Termination of pregnancy by non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Contract Anniversary means the corresponding date in each year after the Contract Date for as long as the Contract is in force.

Contract Date means the date on which coverage for the Employer's Contract with BCBSTX commences.

Contract Month means each succeeding monthly period, beginning on the Contract Date.

Contracting Facility means a Hospital, a Facility Other Provider, or any other facility or institution with which the Carrier has executed a written contract for the provision of care, services, or supplies furnished within the scope of its license for benefits available under the Plan. A Contracting Facility shall also include a Hospital or Facility Other Provider located outside the State of Texas, and with which any other Blue Cross Plan has executed such a written contract; provided, however, any such facility that fails to satisfy each and every requirement contained in the definition of such institution or facility as provided in the Plan shall be deemed a Non-Contracting Facility regardless of the existence of a written contract with another Blue Cross Plan.

[Copayment Amount means the payment, as expressed in dollars, that must be made by or on behalf of a Participant for certain services at the time they are provided.]

Cosmetic, Reconstructive, or Plastic Surgery means surgery that:

1. Can be expected or is intended to improve the physical appearance of a Participant; or
2. Is performed for psychological purposes; or
3. Restores form but does not correct or materially restore a bodily function.

Covered Oral Surgery means maxillofacial surgical procedures limited to:

1. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
2. Incision and drainage of facial abscess;
3. Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses; [and]
4. Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology[.] [;and]

[5. Removal of complete/partial bony impacted teeth.]

Creditable Coverage means coverage provided under:

1. A group health plan that is a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974;
2. Health insurance coverage consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital, or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes:
   a. group health insurance coverage;
   b. individual health insurance coverage; and
   c. short-term, limited-duration insurance;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid) other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines);
5. Title 10 Chapter 55, *United States Code* (medical and dental care for members and certain former members of the uniformed services and for their dependents);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A State health benefits risk pool;
8. A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program);
9. A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;
10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504 (e)); or
11. Title XXI of the Social Security Act (State Children's Health Insurance Program).

***Creditable Coverage does not include**:*

1. Coverage only for accident (including accidental death and dismemberment);
2. Disability income coverage;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Coverage issued as a supplement to liability insurance;
5. Workers' compensation or similar coverage;
6. Automobile medical payment insurance;
7. Credit-only insurance (for example, mortgage insurance);
8. Coverage for onsite medical clinics;
9. Limited scope dental benefits, vision benefits, or long-term care benefits if they are provided under a separate policy, certificate, or contract of insurance.
10. Flexible spending accounts (FSAs) if they meet the definition of a health FSA in IRC Sec. 106(c)(2) and (a) the maximum benefit payable for the employee under the FSA for the year does not exceed two times the employee's salary reduction election under the FSA for the year; and (b) the employee has other coverage available under a group health plan of the employer for the year; and (c) the other coverage is not limited to benefits that are excepted benefits;
11. Coverage for only a specified disease or illness or Hospital indemnity or other fixed indemnity insurance;
12. Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), also known as Medigap or MedSupp insurance);
13. Coverage supplemental to the coverage provided under Chapter 55, Title 10, *United States Code (*also known as TRICARE supplemental programs);
14. Similar supplemental coverage provided to coverage under a group health plan.

Crisis Stabilization Unit or Facility means an institution which is appropriately licensed and accredited as a Crisis Stabilization Unit or Facility for the provision of [Mental Health Care] [and] Serious Mental Illness services to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

Custodial Care means care comprised of services and supplies, including room and board and other institutional services, provided to a Participant primarily to assist in activities of daily living and to maintain life and/or comfort with no reasonable expectation of cure or improvement of sickness or injury. *Custodial Care* is care which is not a necessary part of medical treatment for recovery, and shall include, but not be limited to, helping a Participant walk, bathe, dress, eat, prepare special diets, and take medication.

[Deductible means the dollar amount of Eligible Expenses that must be incurred by a Participant before benefits under the Plan will be available.]

[Deductible means the dollar amount of Eligible Expenses that must be incurred by the Employee, if "Employee only" coverage is elected, before benefits under the Plan will be available. If "Family" coverage is elected, Deductible means the dollar amount of Eligible Expenses that must be incurred by the family before benefits under the Plan will be available.]

Dependent means your spouse or any unmarried *child* covered under the Plan who is:

1. Under the limiting age shown on the Schedule of Coverage; or

2. A *child* of any age who is medically certified as disabled and dependent on the parent for support and maintenance.

   Child means:

   a. Your natural child; or

   b. Your legally adopted child, including a child for whom the Participant is a party in a suit in which the adoption of the child is sought; or

   c. Your stepchild; or

   d. A child of your child who is your dependent for federal income tax purposes at the time application of coverage of the child of your child is made; or

   e. A child for whom a Participant has received a court order requiring that Participant to have financial responsibility for providing health insurance; or

   f. A child not listed above:
      (1) whose primary residence is your household; and
      (2) to whom you are legal guardian or related by blood or marriage; and
      (3) who is dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States.

For purposes of this Plan, the term *Dependent* will also include those individuals who no longer meet the definition of a Dependent, but are beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continued under the appropriate provisions of the *Texas Insurance Code*.

Dietary and Nutritional Services means the education, counseling, or training of a Participant (including printed material) regarding:

1. Diet;
2. Regulation or management of diet; or
3. The assessment or management of nutrition.

Durable Medical Equipment Provider means a Provider that provides therapeutic supplies and rehabilitative equipment and is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Eligible Employee means an Employee who works on a full-time basis, who usually works at least 30 hours a week, and who otherwise meets the *Participation Criteria* established by a Large Employer. The term includes a sole proprietor, a partner, and an independent contractor, if the individual is included as an Employee under a Health Benefit Plan of a Large Employer regardless of the number of hours the sole proprietor, partner, or independent contractor works weekly, but only if the plan includes at least two other eligible employees who work on a full-time basis and who usually work at least 30 hours a week. *Participation Criteria* means any criteria or rules established by a Large Employer to determine the Employees who are eligible for enrollment or continued enrollment under the terms of a Health Benefit Plan. The *Participation Criteria* may not be based on Health Status Related Factors.

Eligible Expenses mean either, Inpatient Hospital Expenses, Medical-Surgical Expenses, Extended Care Expenses, or Special Provisions Expenses, as described in this Benefit Booklet.

Emergency Care means health care services provided in a Hospital emergency facility (emergency room) or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

1. placing the patient's health in serious jeopardy;
2. serious impairment of bodily functions;
3. serious dysfunction of any bodily organ or part;
4. serious disfigurement; or
5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Employee means an individual employed by a Large Employer.

For purposes of this plan, the term *Employee* will also include those individuals who are no longer an Employee of the Large Employer, but who are participants covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continued under the appropriate provisions of the *Texas Insurance Code.*

[*Employees* who have retired under the Large Employer's established procedures whereby individual selection by the Large Employer or the Employee to be included in a retiree classification is precluded, may continue coverage under this Contract].

Environmental Sensitivity means the inpatient or outpatient treatment of allergic symptoms by:

1. Controlled environment; or
2. Sanitizing the surroundings, removal of toxic materials; or
3. Use of special non-organic, non-repetitive diet techniques.

Experimental/Investigational means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical treatment* of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

As used herein, *medical treatment* includes medical, surgical, or dental treatment.

Standard medical treatment means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the Hospital or Facility Other Provider in which they were performed; and

- the Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

The medical staff of BCBSTX shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-financed programs in making its determination.

Although a Physician or Professional Other Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, BCBSTX still may determine such services or supplies to be Experimental/Investigational within this definition. Treatment provided as part of a clinical trial or a research study is Experimental/Investigational.

Extended Care Expenses means the Allowable Amount of charges incurred for those Medically Necessary services and supplies provided by a Skilled Nursing Facility, a Home Health Agency, or a Hospice as described in the **Extended Care Expenses** portion of this Benefit Booklet**.**

Health Benefit Plan means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a Health Maintenance Organization that provides benefits for health care services. The term does not include:

1. Accident only or disability income insurance, or a combination of accident-only and disability income insurance;
2. Credit-only insurance;
3. Disability insurance coverage;
4. Coverage for a specified disease or illness;
5. Medicare services under a federal contract;
6. Medicare supplement and Medicare Select policies regulated in accordance with federal law;
7. Long-term care coverage or benefits, home health care coverage or benefits, nursing home care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;
8. Coverage that provides limited-scope dental or vision benefits;
9. Coverage provided by a single service health maintenance organization;
10. Coverage issued as a supplement to liability insurance;
11. Workers' compensation or similar insurance;
12. Automobile medical payment insurance coverage;
13. Jointly managed trusts authorized under 29 U.S.C. Section 141, et seq., that;
    - contain a plan of benefits for employees
    - is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees, and
    - is authorized under 29 U.S.C. Section 157;
14. Hospital indemnity or other fixed indemnity insurance;
15. Reinsurance contracts issued on a stop-loss, quota-share, or similar basis;
16. Short-term major medical contracts;
17. Liability insurance, including general liability insurance and automobile liability insurance;
18. Other coverage that is:

- similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other insurance benefits; and
- specified in federal regulations;

19. Coverage for onsite medical clinics; or
20. Coverage that provides other limited benefits specified by federal regulations.

Health Status Related Factor means:

1. Health status;
2. Medical condition, including both physical and mental illness;
3. Claims experience;
4. Receipt of health care;
5. Medical history;
6. Genetic information;
7. Evidence of insurability, including conditions arising out of acts of family violence; and
8. Disability.

Home Health Agency means a business that provides Home Health Care and is licensed, approved, or certified by the appropriate agency of the state in which it is located or be certified by Medicare as a supplier of Home Health Care.

Home Health Care means the health care services for which benefits are provided under the Plan when such services are provided during a visit by a Home Health Agency to patients confined at home due to a sickness or injury requiring skilled health services on an intermittent, part-time basis.

Home Infusion Therapy means the administration of fluids, nutrition, or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home Infusion Therapy shall include:

1. Drugs and IV solutions;
2. Pharmacy compounding and dispensing services;
3. All equipment and ancillary supplies necessitated by the defined therapy;
4. Delivery services;
5. Patient and family education; and
6. Nursing services.

Over-the-counter products which do not require a Physician's or Professional Other Provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

Home Infusion Therapy Provider means an entity that is duly licensed by the appropriate state agency to provide Home Infusion Therapy.

Hospice means a facility or agency primarily engaged in providing skilled nursing services and other therapeutic services for terminally ill patients and which is:

1. Licensed in accordance with state law (where the state law provides for such licensing); or
2. Certified by Medicare as a supplier of Hospice Care.

Hospice Care means services for which benefits are provided under the Plan when provided by a Hospice to patients confined at home or in a Hospice facility due to a terminal sickness or terminal injury requiring skilled health care services.

Hospital means a short-term acute care facility which:

1. Is duly licensed as a Hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a Hospital provider under Medicare;

2. Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians for compensation from its patients;

3. Has organized departments of medicine and major surgery, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, and maintains clinical records on all patients;

4. Provides 24-hour nursing services by or under the supervision of a Registered Nurse;

5. Has in effect a Hospital Utilization Review Plan; and

6. Is not, other than incidentally, a Skilled Nursing Facility, nursing home, Custodial Care home, health resort, spa or sanitarium, place for rest, place for the aged, place for the treatment of Chemical Dependency, Hospice, or place for the provision of rehabilitative care.

Hospital Admission means the period between the time of a Participant's entry into a Hospital or a Chemical Dependency Treatment Center as a *Bed patient* and the time of discontinuance of bed-patient care or discharge by the admitting Physician or Professional Other Provider, whichever first occurs. The day of entry, but not the day of discharge or departure, shall be considered in determining the length of a Hospital Admission. If a Participant is admitted to and discharged from a Hospital within a 24-hour period but is confined as a *Bed patient* in a bed accommodation during the period of time he is confined in the Hospital, the admission shall be considered a Hospital Admission by BCBSTX.

Bed patient means confinement in a bed accommodation of a Chemical Dependency Treatment Center on a 24-hour basis or in a bed accommodation located in a portion of a Hospital which is designed, staffed, and operated to provide acute, short-term Hospital care on a 24-hour basis; the term does not include confinement in a portion of the Hospital (other than a Chemical Dependency Treatment Center) designed, staffed, and operated to provide long-term institutional care on a residential basis.

Identification Card means the card issued to the Employee by the Carrier indicating pertinent information applicable to his coverage.

Imaging Center means a Provider that can furnish technical or total services with respect to diagnostic imaging services and is licensed through the Texas State Radiation Control Agency.

Independent Laboratory means a Medicare certified laboratory that provides technical and professional anatomical and/or clinical laboratory services.

[In-Network Benefits means the benefits available under the Plan for services and supplies that are provided by a Network Provider or an Out-of-Network Provider when acknowledged by BCBSTX.]

Inpatient Hospital Expense means the Allowable Amount incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided that such items are:

1. Furnished at the direction or prescription of a Physician or Professional Other Provider; and

2. Provided by a Hospital or a Chemical Dependency Treatment Center; and

3. Furnished to and used by the Participant during an inpatient Hospital Admission.

An expense shall be deemed to have been incurred on the date of provision of the service for which the charge is made.

Inpatient Hospital Expense shall include:

1. Room accommodation charges. If the Participant is in a private room, the amount of the room charge in excess of the Hospital's average semiprivate room charge *is not* an Eligible Expense.

2. All other usual Hospital services, including drugs and medications, which are Medically Necessary and consistent with the condition of the Participant. Personal items *are not* an Eligible Expense.

Medically Necessary [Mental Health Care or] treatment of Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents, in lieu of hospitalization, shall be Inpatient Hospital Expense.

Large Employer (Employer) means a person (individual, corporation, partnership, or other legal entity) who employed an average of at least 51 Eligible Employees on business days during the preceding Calendar Year and who employs at least two Employees on the first day of the plan year.

Late Enrollee means any Employee or Dependent eligible for enrollment who requests enrollment in an Employer's Health Benefit Plan (1) after the expiration of the initial enrollment period established under the terms of the first plan for which that Participant was eligible through the Employer, (2) after the expiration of an Open Enrollment Period, or (3) after the expiration of a special enrollment period.

An Employee or a Dependent is *not* a Late Enrollee if:

1. The individual:

   a. Was covered under another Health Benefit Plan or self-funded Health Benefit Plan at the time the individual was eligible to enroll; and
   b. Declines in writing, at the time of initial eligibility, stating that coverage under another Health Benefit Plan or self-funded Health Benefit Plan was the reason for declining enrollment; and
   c. Has lost coverage under another Health Benefit Plan or self-funded Health Benefit Plan as a result of:
      (1) termination of employment;
      (2) reduction in the number of hours of employment;
      (3) termination of the other plan's coverage;
      (4) termination of contributions toward the premium made by the Employer;
      (5) COBRA coverage or State continuation benefits have been exhausted;
      (6) cessation of Dependent status;
      (7) the individual incurs a claim that would meet or exceed a lifetime limit on all benefits;
      (8) the Plan no longer offers any benefits to the class of similarly situated individuals that include the individual; or
      (9) in the case of coverage offered through an HMO, the individual no longer resides, lives, or works in the service area of the HMO and no other benefit option is available; and
   d. Requests enrollment not later than the 31st day after the date on which coverage under the other Health Benefit Plan or self-funded Health Benefit Plan terminates or in the event of the attainment of a lifetime limit on all benefits, the individual must request to enroll not later that 31 days after a claim is denied due to the attainment of a lifetime limit on all benefits.

2. The individual is employed by an Employer who offers multiple Health Benefit Plans and the individual elects a different Health Benefit Plan during an Open Enrollment Period.
3. A court has ordered coverage to be provided for a spouse under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the court order is issued.
4. A court has ordered coverage to be provided for a child under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the Employer receives notice of the court order.
5. A Dependent child is not a Late Enrollee if the child:

    a. Was covered under Medicaid or the Children's Health Insurance Program (CHIP) at the time the child was eligible to enroll;
    b. The employee declined coverage for the child in writing, stating that coverage under Medicaid or CHIP was the reason for declining coverage;
    c. The child has lost coverage under Medicaid or CHIP; and
    d. The request for enrollment is made not later than the 31st day after the date on which coverage under Medicaid or CHIP terminates.

Marriage and Family Therapy means the provision of professional therapy services to individuals, families, or married couples, singly or in groups, and involves the professional application of family systems theories and techniques in the delivery of therapy services to those persons. The term includes the evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction within the context of marriage or family systems.

Maternity Care means care and services provided for treatment of the condition of pregnancy, other than Complications of Pregnancy.

Medical Social Services means those social services relating to the treatment of a Participant's medical condition. Such services include, but are not limited to assessment of the:

1. Social and emotional factors related to the Participant's sickness, need for care, response to treatment, and adjustment to care; and

2. Relationship of the Participant's medical and nursing requirements to the home situation, financial resources, and available community resources.

Medical-Surgical Expenses means the Allowable Amount for those charges incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided such items are:

1. Furnished by or at the direction or prescription of a Physician or Professional Other Provider; and
2. Not included as an item of Inpatient Hospital Expense or Extended Care Expense in the Plan.

A service or supply is furnished at the direction of a Physician or Professional Other Provider if the listed service or supply is:

1. Provided by a person employed by the directing Physician or Professional Other Provider; and
2. Provided at the usual place of business of the directing Physician or Professional Other Provider; and
3. Billed to the patient by the directing Physician or Professional Other Provider.

An expense shall have been incurred on the date of provision of the service for which the charge is made.

Medically Necessary or **Medical Necessity** means those services or supplies covered under the Plan which are:

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction; and
2. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and
3. Not primarily for the convenience of the Participant, his Physician, the Hospital, or the Other Provider; and
4. The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient.

The medical staff of BCBSTX shall determine whether a service or supply is Medically Necessary under the Plan and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Physician or Professional Other Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition.

Mental Health Care means any one or more of the following:

1. The diagnosis or treatment of a mental disease, disorder, or condition listed in the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*, as revised, or any other diagnostic coding system as used by the Carrier, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin;

2. The diagnosis or treatment of any symptom, condition, disease, or disorder by a Physician or Professional Other Provider (or by any person working under the direction or supervision of a Physician or Professional Other Provider) when the Eligible Expense is:

    a. Individual, group, family, or conjoint psychotherapy,
    b. Counseling,
    c. Psychoanalysis,
    d. Psychological testing and assessment,
    e. The administration or monitoring of psychotropic drugs, or
    f. Hospital visits or consultations in a facility listed in subsection 5, below;

3. Electroconvulsive treatment;

4. Psychotropic drugs;

5. Any of the services listed in subsections 1 through 4, above, performed in or by a Hospital, Facility Other Provider, or other licensed facility or unit providing such care.

[Network means identified Physicians, Professional Other Providers, Hospitals, and other facilities that have entered into agreements with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) for participation in a managed care arrangement.]

[Network Provider means a Hospital, Physician, or Other Provider who has entered into an agreement with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider.]

Non-Contracting Facility means a Hospital, a Facility Other Provider, or any other facility or institution which has not executed a written contract with BCBSTX for the provision of care, services, or supplies for which benefits are provided by the Plan. Any Hospital, Facility Other Provider, facility, or institution with a written contract with BCBSTX which has expired or has been canceled is a Non-Contracting Facility.

Open Enrollment Period means the 31-day period preceding the next Contract Anniversary during which Employees and Dependents may enroll for coverage.

Other Provider means a person or entity, other than a Hospital or Physician, that is licensed where required to furnish to a Participant an item of service or supply described herein as Eligible Expenses. Other Provider shall include:

1. **Facility Other Provider** - an institution or entity, only as listed:

    a. Chemical Dependency Treatment Center
    b. Crisis Stabilization Unit or Facility
    c. Durable Medical Equipment Provider
    d. Home Health Agency
    e. Home Infusion Therapy Provider
    f. Hospice
    g. Imaging Center
    h. Independent Laboratory
    i. Prosthetics/Orthotics Provider
    j. Psychiatric Day Treatment Facility
    k. Renal Dialysis Center
    l. Residential Treatment Center for Children and Adolescents
    m. Skilled Nursing Facility
    n. Therapeutic Center

2. **Professional Other Provider** - a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:

    a. Advanced Practice Nurse
    b. Doctor of Chiropractic
    c. Doctor of Dentistry
    d. Doctor of Optometry
    e. Doctor of Podiatry
    f. Doctor in Psychology
    g. Licensed Acupuncturist
    h. Licensed Audiologist
    i. Licensed Chemical Dependency Counselor
    j. Licensed Dietitian
    k. Licensed Hearing Instrument Fitter and Dispenser
    l. Licensed Marriage and Family Therapist
    m. Licensed Clinical Social Worker
    n. Licensed Occupational Therapist
    o. Licensed Physical Therapist
    p. Licensed Professional Counselor
    q. Licensed Speech-Language Pathologist
    r. Licensed Surgical Assistant
    s. Nurse First Assistant
    t. Physician Assistant

u. Psychological Associates who work under the supervision of a Doctor in Psychology

The listings shown, above, in 1. and 2., unless otherwise defined in the Plan, shall have the meaning assigned to them by the *Texas Insurance Code*. In states where there is a licensure requirement, other Providers must be licensed by the appropriate state administrative agency.

[Out-of-Network Benefits means the benefits available under the Plan for services and supplies that are provided by an Out-of-Network Provider.]

[Out-of-Network Provider means a Hospital, Physician, or Other Provider who has not entered into an agreement with BCBSTX (or other participating Blue Cross and/or Blue Shield Plan) as a managed care Provider.]

[Out-of-Pocket Maximum means the cumulative dollar amount of Eligible Expenses [,including the Calendar Year Deductible,] incurred by a Participant during a Calendar Year.]

[Out-of-Pocket Maximum means, if "Employee only" coverage is elected, the cumulative dollar amount of Eligible Expenses, including the Calendar Year Deductible, incurred by the Employee during a Calendar Year. If "Family" coverage is elected, Out-of-Pocket Maximum means the cumulative dollar amount of Eligible Expenses, including the Calendar Year Deductible, incurred by the family during a Calendar Year.]

Outpatient Contraceptive Services means a consultation, examination, procedure, or medical service that is provided on an outpatient basis and that is related to the use of a drug or device intended to prevent pregnancy.

Participant means an Employee [or] Dependent [or a retiree] whose coverage has become effective under this Contract.

Physical Medicine Services means those modalities, procedures, tests, and measurements listed in the *Physicians' Current Procedural Terminology Manual* (Procedure Codes 97010-97799), whether the service or supply is provided by a Physician or Professional Other Provider, and includes, but is not limited to, physical therapy, occupational therapy, hot or cold packs, whirlpool, diathermy, electrical stimulation, massage, ultrasound, manipulation, muscle or strength testing, and orthotics or prosthetic training.

Physician means a person, when acting within the scope of his license, who is a Doctor of Medicine or Doctor of Osteopathy. The terms Doctor of Medicine or Doctor of Osteopathy shall have the meaning assigned to them by the *Texas Insurance Code*.

[Plan Service Area means the geographical area or areas specified in the Contract in which a Network of Providers is offered and available and is used to determine eligibility for **Managed Health Care Plan** benefits.]

Preexisting Condition means a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the [three] [six] months before the earlier of the:

- Effective Date of Coverage; or
- First day of the Preexisting Condition waiting period.

Proof of Loss means written evidence of a claim including:

1. The form on which the claim is made;
2. Bills and statements reflecting services and items furnished to a Participant and amounts charged for those services and items that are covered by the claim, and
3. Correct diagnosis code(s) and procedure code(s) for the services and items.

Prosthetic Appliances means artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). For purposes of this definition, a wig or hairpiece is not considered a Prosthetic Appliance.

Prosthetics/Orthotics Provider means a certified prosthetist that supplies both standard and customized prostheses and orthotic supplies.

Provider means a Hospital, Physician, Other Provider, or any other person, company, or institution furnishing to a Participant an item of service or supply listed as Eligible Expenses.

Psychiatric Day Treatment Facility means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Healthcare Organizations as a Psychiatric Day Treatment Facility for the provision of [Mental Health Care and] Serious Mental Illness services to Participants for periods of time not to exceed eight hours in any 24-hour period. Any treatment in a Psychiatric Day Treatment Facility must be certified in writing by the attending Physician to be in lieu of hospitalization.

Renal Dialysis Center means a facility which is Medicare certified as an end-stage renal disease facility providing staff assisted dialysis and training for home and self-dialysis.

Residential Treatment Center for Children and Adolescents means a child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children as a residential treatment center for the provisions of [Mental Health Care and] Serious Mental Illness services for emotionally disturbed children and adolescents.

Serious Mental Illness means the following psychiatric illnesses defined by the *American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):*

1. Bipolar disorders (hypomanic, manic, depressive, and mixed);
2. Depression in childhood and adolescence;
3. Major depressive disorders (single episode or recurrent);
4. Obsessive-compulsive disorders;
5. Paranoid and other psychotic disorders;
6. Pervasive developmental disorders;
7. Schizo-affective disorders (bipolar or depressive); and
8. Schizophrenia.

Skilled Nursing Facility means a facility primarily engaged in providing skilled nursing services and other therapeutic services and which is:

1. Licensed in accordance with state law (where the state law provides for licensing of such facility); or
2. Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care.

[Specialty Care Provider means a Physician or Professional Other Provider who has entered into an agreement with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider of specialty services.]

Telehealth Service means a health service, other than a Telemedicine Medical Service, delivered by a licensed or certified health professional Provider acting within the scope of the health care professional Provider's license or certification who does not perform a Telemedicine Medical Service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

1. Compressed digital interactive video, audio, or data transmission;
2. Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
3. Other technology that facilitates access to health care services or medical specialty expertise.

Telemedicine Medical Service means a health care service initiated by a Physician or provided by a health professional Provider acting under Physician delegation and supervision for purposes of patient assessment by a health professional, diagnosis, or consultation by a Physician, treatment or the transfer of medical data that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

1. Compressed digital interactive video, audio or data transmission;
2. Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
3. Other technology that facilitates access to health care services or medical specialty expertise.

Therapeutic Center means an institution which is appropriately licensed, certified, or approved by the state in which it is located and which is:

1. An ambulatory (day) surgery facility;
2. A freestanding radiation therapy center; or
3. A freestanding birthing center.

Waiting Period means a period established by an Employer that must pass before an individual who is a potential enrollee in a Health Benefit Plan is eligible to be covered for benefits.

OUTPATIENT PRESCRIPTION DRUG EXPENSES

This portion of your Plan provides coverage for Medically Necessary Covered Drugs prescribed to treat a Participant for a chronic, disabling, or life-threatening illness covered under the Plan if the drug:

1. Has been approved by the United States Food and Drug Administration (FDA) for at least one indication; and
2. Is recognized by the following for treatment of the indication for which the drug is prescribed
   a. a prescription drug reference compendium approved by the Department of Insurance, or
   b. substantially accepted peer-reviewed medical literature.

As new drugs are approved by the U. S. Food and Drug Administration (FDA), such drugs, unless the intended use is specifically excluded under the Plan, are eligible for benefits. Benefits are available for Covered Drugs as indicated on your Schedule of Coverage under "Outpatient Prescription Drug Expenses."

How it Works

When you need a Prescription Order filled, you can elect to go to a Participating Pharmacy or a Non-Participating Pharmacy [or use the Mail Service Pharmacy].[When you need a Specialty Drug Prescription Order filled, you may incur less out-of-pocket expenses by utilizing a BCBSTX Preferred Specialty Drug Provider.]

[***Participating Pharmacy***
When you go to a Participating Pharmacy, present your Identification Card to the pharmacist along with your Prescription Order. The pharmacist will use the information on your Identification Card to determine that you are a BCBSTX Subscriber. You will be charged the Allowable Amount that the Pharmacy has negotiated with BCBSTX as the full amount of your bill. You must then submit a claim form and itemized receipts to the Carrier verifying that the prescription was filled.

NOTE: If your Employer's Group Health Plan includes a Calendar Year Deductible or a Prescription Drug Deductible, no benefits will be payable under this benefit until the appropriate Deductible amount has been fully satisfied.

Once you submit your claim, the Carrier will reimburse you for Covered Drugs equal to:

- [the Coinsurance Amount indicated on your Schedule of Coverage for the Allowable Amount of the Prescription Order]
- [less any Copayment Amount indicated on your Schedule of Coverage]
- [less any remaining portion of the Calendar Year Deductible [or Prescription Drug Deductible] that has not been previously satisfied]
- [up to the Prescription Drug Calendar Year Maximum indicated on your Schedule of Coverage.]

You will not be responsible for any charges over your share of the Allowable Amount of the Covered Drugs **except any applicable items indicated in the paragraph above.**

If you are unsure whether a Pharmacy is a Participating Pharmacy, you may access our website at www.bcbstx.com or contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card.]

[***Participating Pharmacy***
When you go to a Participating Pharmacy, present your Identification Card to the pharmacist along with your Prescription Order. The pharmacist will use the information on your Identification Card to determine that you are a BCBSTX Subscriber.

NOTE: If your Plan includes a Calendar Year Deductible or a Prescription Drug Deductible, no benefits will be payable under this benefit until the appropriate Deductible amount has been fully satisfied.

OUTPATIENT PRESCRIPTION DRUG EXPENSES

[After you have satisfied all applicable Deductible amounts,] your payment at the Pharmacy for the Covered Drugs will be:

- [the Coinsurance Amount indicated on your Schedule of Coverage for the Allowable Amount of the Prescription Order]
- [the appropriate Copayment Amount indicated on your Schedule of Coverage for each Prescription Order filled or refilled] [and the pricing difference when it applies to the Covered Drug you receive]
- [plus any remaining portion of the [Prescription Drug Deductible] [or] [Calendar Year Deductible] that has not been previously satisfied]

You will not be responsible for any charges over your share of the Allowable Amount of the Covered Drugs **except any applicable items indicated in the paragraph above.**

If you are unsure whether a Pharmacy is a Participating Pharmacy, you may access our website at www.bcbstx.com or contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card.]

Non-Participating Pharmacy
If you have a Prescription Order filled at a Non-Participating Pharmacy, you must pay the Pharmacy the full cost of the drug and submit a claim form to the Carrier with itemized receipts verifying that the Prescription Order was filled.

NOTE: If your Plan includes a Calendar Year Deductible or a Prescription Drug Deductible, no benefits will be payable under the Plan until the appropriate Deductible amount has been fully satisfied.]

[After you have satisfied all applicable Deductible amounts,] the Plan will reimburse you for Covered Drugs equal to:

- [the Coinsurance Amount indicated on your Schedule of Coverage for the Allowable Amount of the Prescription Order]
- [less any Copayment Amount indicated on your Schedule of Coverage for each Prescription Order filled or refilled] [and the pricing difference when it applies to the Covered Drug you receive]
- [less any remaining portion of the [Prescription Drug Deductible] [or] [Calendar Year Deductible]]
- [up to the Prescription Drug Calendar Year Maximum indicated on your Schedule of Coverage.]

You will not be reimbursed for any charges over the Allowable Amount of the Covered Drugs.

[***Mail Service Pharmacy***
Your Employer has chosen to provide a Mail Service Pharmacy arrangement to you and your covered Dependents. The [Calendar Year Deductible] [Prescription Drug Deductible] [Prescription Drug Calendar Year Maximum] [Coinsurance Amounts] [and] [Copayment Amounts] [are] [is] indicated on your Schedule of Coverage.

When you receive Covered Drugs through the Mail Service Pharmacy, a *Mail Order Form* must be submitted. This form can be obtained from the Carrier, your Employer, or you may access the form from the BCBSTX website, www.bcbstx.com. Instructions for completing the form are provided on the form. These forms are mailed to:

Blue Cross and Blue Shield of Texas
[c/o PrimeMail Pharmacy
P.O. Box 650041
Dallas, TX 75265-0041]

When you mail your Prescription Orders to the address provided on the *Mail Order Form*, you must send in your payment. If you need assistance in determining the amount of your payment, you may either contact the Customer Service Helpline for assistance or send the amount of payment you determine will be needed.

If you send an incorrect payment amount for the Covered Drug dispensed, you will: (a) receive a credit if the payment is too much; or (b) be billed for the appropriate amount if it is not enough.

If you have any questions about the Program or need to obtain the *Mail Order Form*, you may access our website at www.bcbstx.com or call the Customer Service Helpline at the telephone number shown in this Benefit Booklet or on your Identification Card.]

[***Specialty Drug Program***
Each time you need a Prescription Order filled for a Covered Drug that has been classified as a Specialty Drug, you may elect to use a BCBSTX Preferred Specialty Drug Provider or a Participating Pharmacy. A list identifying these Specialty Drugs is available by accessing the BCBSTX website at www.bcbstx.com or by contacting the Customer Service helpline number shown in this Benefit Booklet or on your Identification Card. [Your cost will be the Coinsurance Amount indicted on your Schedule of Coverage for each provider.] [It is important to note that if a Covered Drug is on the Specialty Drug List, the provisions in the subsection entitled ***Preferred Brand Name Drug List*** are inapplicable. The Specialty Drug List will identify Specialty Drugs and will classify them as a Generic Drug or a brand name drug. Your cost will be the appropriate Specialty Drug Copayment Amount indicated on your Schedule of Coverage for each provider plus any pricing differentials that may apply based on the classification status of the Specialty Drug you receive.] [You will also be responsible for any Deductible amounts that may apply to your coverage.] You or your prescribing Physician can locate a Preferred Specialty Drug Provider by contacting the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card. Utilizing a Preferred Specialty Drug Provider for your Specialty Drug Prescription Order will usually be your most cost effective option.]

[Diabetes Supplies [and Blood Glucose Monitors] for Treatment of Diabetes
Benefits are available for Medically Necessary items of Diabetes Supplies [and blood glucose monitors (including non-invasive monitors and monitors for the blind)] for which a Physician or authorized Professional Other Provider has written an order. Such Diabetes Supplies, when obtained for a Qualified Participant (for more information regarding Qualified Participant, refer to the ***Benefits for Treatment of Diabetes*** section of the medical portion of this Benefit Booklet), shall include but not be limited to the following:

- [Test strips specified for use with a corresponding blood glucose monitor]
- [Lancets and lancet devices]
- [Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein]
- [Insulin and insulin analog preparations]
- [Injection aids, including devices used to assist with insulin injection and needleless systems]
- [Insulin syringes]
- [Biohazard disposable containers]
- [Prescriptive and non-prescriptive oral agents for controlling blood sugar levels,] [and]
- [Glucagon emergency kits]

You are responsible for any [Prescription Drug Deductibles], [Calendar Year Deductibles], [Copayment Amounts] [Coinsurance Amounts], and any pricing differences that may apply to the items dispensed.]

[***Preferred Drug List***
A Preferred Brand Name Drug is subject to the Preferred Brand Name Drug Copayment Amount plus any pricing differences that may apply to the Covered Drug you receive. These drugs are identified on a *Preferred Drug List.* This *Preferred Drug List* is developed in consultation with a group of physicians and pharmacists responsible for interpreting clinical drug information. Published peer-reviewed medical journals and commonly accepted treatment guidelines are used to evaluate new and existing therapies for safety, efficacy, and cost. Drugs identified on the list are reviewed on an ongoing basis to assure optimal assignment.

Periodic adjustments will be made to modify the Preferred or Non-Preferred Brand Name Drug status of existing or new drugs. Re-classifying a drug on this list from a Preferred Brand name Drug to a Non-Preferred Brand Name Drug will be implemented on the Employer's Contract Anniversary. The *Preferred Drug List* and any modifications will be made available to Participants. Participants may access our website a www.bcbstx.com or call the Customer Service Helpline at the telephone number shown in this Benefit Booklet or on your Identification Card to determine if a particular drug is on the *Preferred Drug List.* Drugs that do not appear on the *Preferred Drug List* may be subject to the Non-Preferred Brand Name Drug Copayment Amount plus any pricing differences that may apply to the Covered Drug you receive.]

[***Prior Authorizations***
To ensure that a drug is safe, effective, and part of a specific treatment plan, certain medications may require prior authorization and the evaluation of additional clinical information before dispensing. A list of the medications which require prior authorization is available to you on our website at www.bcbstx.com.

When you present a Prescription Order to a Participating Pharmacy [or] [through the Mail Service Pharmacy] [or] [through Preferred Specialty Drug Providers] for one of these designated medications, your Physician or authorized Professional Other Provider will be required to submit a *Prior Authorization Request* form on your behalf before the medication can be dispensed. This form may also be submitted by your Physician or authorized Professional Other Provider in advance of the request to the Pharmacy. The Physician or authorized Professional Other Provider can obtain the *Prior Authorization Request* form by accessing our website at www.bcbstx.com. The requested medication may be approved or denied in accordance with established clinical criteria.

Non-Participating Pharmacies cannot access the criteria for prior authorizations online. It is important to contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card prior to using one of these Pharmacies since Prescription Orders obtained through a Non-Participating Pharmacy may be denied for reimbursement based upon this criteria.]

[Limitations on Quantities Dispensed -] Day Supply

Benefits for Covered Drugs obtained from a Participating Pharmacy, [or] a Non-Participating Pharmacy, [or] [through the Mail Service Pharmacy] [or] [through Preferred Specialty Drug Providers] are provided up to the maximum day supply limit indicated on your Schedule of Coverage. The [Coinsurance Amount] [and] [Copayment Amount] applicable for the designated day supply of dispensed drugs for retail Pharmacies [and] [through the Mail Service Pharmacy] [and] [through Preferred Specialty Drug Providers] [are] [is] indicated on your Schedule of Coverage.

[If a Prescription Order is written for a certain quantity of medication to be taken in a time period directed by a Physician or an authorized Professional Other Provider, the Prescription Order will only be covered for a clinically appropriate pre-determined quantity of medication for the specified amount of time. To determine if a specific drug is subject to this limitation, contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card.

The supply of a given prescription drug indicates the number of units to be dispensed and is determined based on pertinent medical information and clinical efficacy and safety. Quantities of some drugs are restricted regardless of the quantity ordered by the Physician or authorized Professional Other Provider. The Carrier has the right to determine the day supply at its sole discretion.

Payment for benefits covered under this Plan **may be denied** if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation. Participants requiring Prescription Orders in excess of the day supply limit established by BCBSTX may ask their Physician or authorized Professional Other Provider to submit a request for clinical review on their behalf. The Physician or authorized Professional Other Provider can obtain the *Quantity Limit Override Request* form by accessing our website at www.bcbstx.com. Any pertinent medical information along with the completed form should be faxed to Clinical Pharmacy Programs at the fax number indicated on the form. The request will be approved or denied after evaluation of the submitted clinical information.]

[***Right of Appeal***
In the event that a Prescription Order is still denied on the basis of [prior authorization criteria] [or] [a day supply limit] after your Physician or authorized Professional Other Provider has submitted clinical documentation, you have the right to appeal as indicated under the **Review of Claim Determinations** section of this Benefit Booklet.]

OUTPATIENT PRESCRIPTION DRUG EXPENSES

[Deductibles,] [and] [Maximums][, and] [Copayment Amounts]

[***Prescription Drug Deductible***
The Prescription Drug Deductible shown on your Schedule of Coverage is the dollar amount of Covered Drug expenses that must be satisfied by each Participant each Calendar Year before benefits under Outpatient Prescription Drug Expenses portion of the Plan will be available. The Prescription Drug Deductible will apply to Covered Drugs obtained through retail Pharmacies [and][,] [through the Mail Service Pharmacy] [and through Preferred Specialty Drug Providers]. After the Prescription Drug Deductible is met, benefits as shown on your Schedule of Coverage will be available.

Whether you use a Participating Pharmacy, [or] a Non-Participating Pharmacy, [or][,] [the Mail Service Pharmacy,] [or a Preferred Specialty Drug Provider,] the Allowable Amount of your Covered Drug expenses will be applied toward satisfaction of your Prescription Drug Deductible.

If you use a Participating Pharmacy [or a Preferred Specialty Drug Provider], the pharmacist [or provider] can tell you once the Prescription Drug Deductible has been satisfied or you may contact the Customer Service Helpline for this information. If you use a Non-Participating Pharmacy, you should contact the Customer Service Helpline prior to going to the Pharmacy to determine if your Prescription Drug Deductible has been satisfied since Non-Participating Pharmacies cannot access this information online.]

[***Prescription Drug Calendar Year Maximum***
The Prescription Drug Calendar Year Maximum shown on your Schedule of Coverage is the total amount of benefits available under Outpatient Prescription Drug Expenses portion of your Plan for a Calendar Year. The Prescription Drug Calendar Year Maximum will apply to each Participant separately and will include all payments made under the Outpatient Prescription Drug Expenses benefit; whether through a Participating Pharmacy, [or] a Non-Participating Pharmacy, [or][,] [under the Mail Service Pharmacy] [or a Preferred Specialty Drug Provider].

Once a Participant has reached the Prescription Drug Calendar Year Maximum, no additional benefits for Covered Drugs will be available until the next Calendar Year benefit period begins.]

[The Calendar Year Deductible shown on your Schedule of Coverage must be satisfied by each Participant each Calendar Year before benefits will be available.]

[Copayment Amounts
Copayment Amounts for a Participating Pharmacy [or] Non-Participating Pharmacy [or][,] [the Mail Service Pharmacy] [or a Preferred Specialty Drug Provider] are shown on your Schedule of Coverage. The amount you pay depends on the Covered Drug dispensed. If the Covered Drug dispensed is a:

[1.] Generic Drug - You pay the Generic Drug Copayment Amount

[2.] [Brand Name Drug - You pay the Brand Name Drug Copayment Amount]

[3.] [Preferred Brand Name Drug – You pay the Preferred Brand Name Drug Copayment Amount]

[4.] [Non-Preferred Brand Name Drug – You pay the Non-Preferred Brand Name Drug Copayment Amount]

[5.] [Specialty Drug – You pay the Specialty Drug Copayment Amount]

If the Allowable Amount of the Covered Drug is less than the Copayment Amount, the Participant will pay the lower cost.

*[**How Copayment Amounts Apply***
When your Physician or authorized Professional Other Provider has marked the Prescription Order "Brand Necessary" or "Brand Medically Necessary," the pharmacist may *only* dispense the brand name drug and you pay the appropriate Brand Name Drug Copayment Amount.

If the Physician or authorized Professional Other Provider has not stipulated a dispensing directive prohibiting substitution of a generic equivalent (Brand Necessary or Brand Medically Necessary), you may still choose to buy the brand name drug instead of the Generic Drug.

Your payment amount will be the sum of:

(a) the Brand Name Drug Copayment Amount, **plus**
(b) the difference between the Allowable Amount of the Generic Drug and the Allowable Amount of the brand name drug.]

*[**How Brand Name Drug Pricing Difference Applies***
When a Generic Drug is available but your Physician or authorized Professional Other Provider has marked the Prescription Order "Brand Necessary" or "Brand Medically Necessary" OR your choose to receive the brand name drug instead of the Generic Drug, your payment amount will be determined as follows:

(a) the difference between the Allowable Amount of the brand name drug and the Allowable Amount of the Generic Drug, **plus**
(b) the Brand Name Drug Copayment Amount.]

*[**How Copayment Amounts Apply***
When your Physician or authorized Professional Other Provider has marked the Prescription Order "Brand Necessary" or "Brand Medically Necessary," the pharmacist may *only* dispense the brand name drug and you pay the appropriate Brand Name Drug Copayment Amount.

If the Physician or authorized Professional Other Provider has not stipulated a dispensing directive prohibiting substitution of a generic equivalent (Brand Necessary or Brand Medically Necessary), you may still receive the brand name drug instead of the Generic Drug.

If the brand name drug dispensed is on the *Preferred Drug List*, your payment amount will be the sum of:

(a) the Preferred Brand Name Drug Copayment Amount, **plus**
(b) the difference between the Allowable Amount of the Generic Drug and the Allowable Amount of the Preferred Brand Name Drug.

If the brand name drug dispensed is a Non-Preferred Brand Name Drug, your payment amount will be the sum of:

(a) the Preferred Brand Name Drug Copayment Amount, **plus**
(b) the difference between the Allowable Amount of the Generic Drug and the Allowable Amount of the Non-Preferred Brand Name Drug.]

[How Preferred Brand Name Drug Pricing Difference Applies
When a Generic Drug is available but your Physician or authorized Professional Other Provider has marked the Prescription Order "Brand Necessary" or Brand Medically Necessary" OR you choose to receive the brand name drug instead of the Generic Drug, your payment amount will be determined as follows:

(a) the difference between the Allowable Amount of the Preferred Brand Name Drug and the Allowable Amount of the Generic Drug, plus

(b) the Preferred Brand Name Drug Copayment Amount.

If there is no Generic Drug for your Non-Preferred Brand Name Drug Prescription Order, you will pay no more than the applicable Non-Preferred Brand Name Drug Copayment Amount. If you receive a Non-Preferred Brand Name Drug when a Generic Drug is available, your payment amount will be the sum of:

(a) the difference between the Allowable Amount of the Non-Preferred Brand Name Drug and the Allowable Amount of the Generic Drug, **plus**
(b) the Preferred Brand Name Drug Copayment Amount.]

[***How Copayment Amounts Apply – Specialty Drug Program***
For your Specialty Drug Prescription Order, when your Physician has marked the Prescription Order "Brand Necessary" or "Brand Medically Necessary," the pharmacist may only dispense the brand name drug and you pay the appropriate Specialty Drug Copayment Amount.

If the Physician has not stipulated a dispensing directive prohibiting substitution of a generic equivalent (Brand Necessary or Brand Medically Necessary), you may still choose to buy the brand name drug instead of the Generic Drug. Your payment amount will be the sum of:

(a) the difference between the Allowable Amount of the Generic Drug and the Allowable Amount of the brand name drug, **plus**
(b) the Specialty Drug Copayment Amount.]

[***How Brand Name Drug Pricing Difference Applies – Specialty Drug Program***
For your Specialty Drug Prescription Order, if there is no Generic Drug for your brand name drug, you will pay no more than the applicable Specialty Drug Copayment Amount.

If you receive a brand name drug when a Generic Drug is available, your payment amount will be the sum of:

(a) the difference between the Allowable Amount of the Generic Drug and the Allowable Amount of the brand name drug, **plus**
(b) the Specialty Drug Copayment Amount.]

Limitations and Exclusions

The benefits as described in this provision are not available for:

1. Drugs which do not by law require a Prescription Order from a Provider (**except** insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels); and drugs or covered devices for which no valid Prescription Order is obtained.

2. Devices [or durable medical equipment] of any type (even though such devices may require a Prescription Order,) such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices (provided that disposable hypodermic needles and syringes for self-administered injections [and those devices listed as Diabetes Supplies] shall be specific exceptions to this exclusion).

3. [Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is **no** non-prescription alternative.)]

4. Drugs dispensed in a Physician's or authorized Professional Other Provider's office or during confinement while a patient is in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.

5. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.

6. Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid), or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that the exclusions of this section shall not be applicable to any coverage held by the Participant for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

7. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery.

8. Covered Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the Participant's cost share determined under this Plan.

9. [Contraceptive devices, non-prescription contraceptive materials, (including prescription contraceptive drugs which are Legend Drugs, unless prescription contraceptive coverage is necessary to preserve the life or health of the Participant).]

10. [Oral and injectable infertility and fertility medications.]

11. [Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.]

12. Drugs required by law to be labeled: "Caution - Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made for the drugs.

13. Drugs dispensed in quantities in excess of the day supply amounts stipulated in your Schedule of Coverage, [certain Covered Drugs exceeding the clinically appropriate predetermined quantity], or refills

of any prescriptions in excess of the number of refills specified by the Physician or authorized Professional Other Provider or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.

14. Legend Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.

15. Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting. NOTE: this exclusion does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.

16. [Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.]

17. Drugs, that the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.

18. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.

19. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your Employer's group health care plan, or for which benefits have been exhausted.

20. [Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.]

21. [Services and supplies for smoking cessation programs and the treatment of nicotine addiction.]

22. Compounded drugs that do not meet the definition of Compound Drugs in this portion of your Benefit Booklet.

23. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.

24. [Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s).]

25. [Retin A or pharmacologically similar topical drugs.]

26. Athletic performance enhancement drugs.

27. [Drugs to treat sexual dysfunction, including, but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine in oral and topical form.]

28. Allergy serum and allergy testing materials.

29. [Benefits for any Prescription Orders in excess of the Prescription Drug Calendar Year Maximum specified on your Schedule of Coverage.]

30. [Prescription Orders which do not meet the required prior authorization criteria.]

OUTPATIENT PRESCRIPTION DRUG EXPENSES

Definitions

(In addition to the applicable terms provided in the **DEFINITIONS** *section of the Benefit Booklet, the following terms will apply specifically to this* **OUTPATIENT PRESCRIPTION DRUG EXPENSES** *section.)*

Allowable Amount means the maximum amount determined by BCBSTX to be eligible for consideration of payment for a particular Covered Drug.

1. As applied to Participating Pharmacies [and][,] the Mail Service Pharmacy,] [and Preferred Specialty Drug Providers,] the Allowable Amount is based on the provisions of the contract between BCBSTX and the Participating Pharmacy [or Pharmacy for the Mail Service Pharmacy] [or] [the Preferred Specialty Drug Provider] in effect on the date of service.

2. As applied to Non-Participating Pharmacies, the Allowable Amount is based on the Average Wholesale Price.

Average Wholesale Price means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a Pharmacy.

[**Coinsurance Amount** means the dollar amount of Covered Drugs incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan.]

Compound Drugs means those drugs that meet the following requirements:

1. The drugs in the compounded product are Food and Drug Administration (FDA) approved;
2. The approved product has an assigned National Drug Code (NDC); and
3. The primary active ingredient is a Covered Drug under the Outpatient Prescription Drug Expense benefit.

[**Copayment Amount**, with respect to Outpatient Prescription Drug Expenses, means [the dollar amount] [the percentage amount] [the dollar amount followed by the percentage amount] paid by the Participant for each Prescription Order filled or refilled through a retail Pharmacy [or through the Mail Service Pharmacy] [or] [through Preferred Specialty Drug Providers]].

Covered Drugs means any Legend Drug (including insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, with disposable syringes and needles needed for self-administration):

1. Which is Medically Necessary and is ordered by a Physician or authorized Professional Other Provider naming a Participant as the recipient;
2. For which a written or verbal Prescription Order is provided by a Physician or authorized Professional Other Provider;
3. For which a separate charge is customarily made;
4. Which is not entirely consumed at the time and place that the Prescription Order is written;
5. For which the U.S. Food and Drug Administration (FDA) has given approval for a particular use or purpose; and
6. Which is dispensed by a Pharmacy and is received by the Participant while covered under the Plan, **except when** received from a Provider's office, or during confinement while a patient in a hospital or other acute care institution or facility (refer to **Limitations and Exclusions**).

Generic Drug means a drug which is approved by the U.S. Food and Drug Administration (FDA) as pharmaceutically and therapeutically equivalent for a particular use or purpose to the brand name drug prescribed.

Legend Drugs means drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution - Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose.

National Drug Code (NDC) means a national classification system for the identification of drugs.

Non-Participating Pharmacy means a retail Pharmacy that has not entered into an agreement to provide prescription drug services to Participants under an outpatient prescription drug plan.

[**Non-Preferred Brand Name Drug** means a brand name drug which does not appear on the *Preferred Brand Name Drug List.*]

[**Non-Preferred Brand Name Drug Copayment Amount** means the Copayment Amount applicable if a Non-Preferred Brand Name Drug is dispensed.]

Participating Pharmacy means an independent retail Pharmacy or chain of retail Pharmacies which have entered into an agreement to provide prescription drug services to Participants under the Prescription Drug Program.

Pharmacy means a state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he practices.

[**Preferred Brand Name Drug** means a brand name drug which appears on the *Preferred Brand Name Drug List.]*

[**Preferred Brand Name Drug Copayment Amount** means the Copayment Amount applicable if a Preferred Brand Name Drug is dispensed.]

[**Preferred Specialty Drug Providers** mean those providers that have entered into an agreement to provide Specialty Drugs under the Prescription Drug Program portion of your Plan.]

Prescription Order means a written or verbal order from a Physician or authorized Professional Other Provider to a pharmacist for a drug or device to be dispensed. Orders written by Physicians or authorized Professional Other Providers located outside the United States to be dispensed in the United States are not covered under the Plan**.**

[**Specialty Drugs** means those legend drugs that (1) are unique, high-cost medications that may be given by any route of administration,(2) benefit a limited patient population, and (3) typically require complex dispensing technique, delivery procedures, and/or patient education and support.]

[**Specialty Drug Copayment Amount** means the Copayment Amount applicable if a Specialty Drug is dispensed.]

PRESCRIPTION DRUG PROGRAM

This portion of your Plan provides coverage for Medically Necessary Covered Drugs prescribed to treat a Participant for a chronic, disabling, or life-threatening illness covered under the Plan if the drug:

1. Has been approved by the United States Food and Drug Administration (FDA) for at least one indication; and
2. Is recognized by the following for treatment of the indication for which the drug is prescribed
   a. a prescription drug reference compendium approved by the Department of Insurance, or
   b. substantially accepted peer-reviewed medical literature.

As new drugs are approved by the Food and Drug Administration (FDA), such drugs, unless the intended use is specifically excluded under the Plan, are eligible for benefits. Benefits are available for Covered Drugs as indicated on your Schedule of Coverage.

How the Program Works

When you need a Prescription Order filled, you can elect to go to a Participating Pharmacy or a Non-Participating Pharmacy [or use the Mail Service Prescription Drug Program.][When you need a Specialty Drug Prescription Order filled, you may incur less out-of-pocket expenses by utilizing a BCBSTX Preferred Specialty Drug Provider.]

Participating Pharmacy
When you go to a Participating Pharmacy:

- present your Identification Card to the pharmacist along with your Prescription Order,
- provide the pharmacist with the birth date and relationship of the patient,
- sign the insurance claim log,
- [pay the Prescription Drug Deductible,]
- [pay your portion of the Coinsurance Amount, and]
- pay the appropriate Copayment Amount for each Prescription Order filled or refilled [and the pricing difference when it applies to the Covered Drug you receive.]

Participating Pharmacies have agreed to accept as payment in full the least of:

- the billed charges, or
- the Allowable Amount as determined by BCBSTX, or
- other contractually determined payment amounts.

You are responsible for paying any [Deductibles,] [and] [Copayment Amounts,] [and] [Coinsurance Amounts.], [and] any pricing differences, when applicable. You may be required to pay for limited or non-covered services. No claim forms are required.

If you are unsure whether a Pharmacy is a Participating Pharmacy, you may access our website at www.bcbstx.com or contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card.

Non-Participating Pharmacy
If you have a Prescription Order filled at a Non-Participating Pharmacy, you must pay the Pharmacy the full amount of its bill and submit a claim form to the Carrier with itemized receipts verifying that the Prescription Order was filled. The Plan will reimburse you for Covered Drugs equal to:

- [80%] of the Allowable Amount,
- [less the Prescription Drug Deductible,]

- [less the appropriate Copayment Amount] [,and]
- [less any pricing differences that may apply to the Covered Drug you receive.]

[***Mail Service Prescription Drug Program***
Your Employer has chosen to provide a Mail Service Prescription Program to you and your covered Dependents. The [Prescription Drug Deductible] [Prescription Drug Calendar Year Maximum,] [Coinsurance Amount,] [and] [Copayment Amount] [are] [is] indicated on your Schedule of Coverage.

When you mail your Prescription Orders to the address provided on the *Mail Service Prescription Drug Program Claim Form,* you must send in your payment. If you need assistance in determining the amount of your payment, you may either contact the Customer Service Helpline for assistance or send the amount of payment you determine will be needed.

If you send an incorrect payment amount for the Covered Drug dispensed, you will: (a) receive a credit if the payment is too much; or (b) be billed for the appropriate amount if it is not enough.

If you have any questions about the Program or need to obtain the *Mail Service Prescription Drug Program Claim Form*, you may access our website at www.bcbstx.com or call the Customer Service Helpline at the telephone number shown in this Benefit Booklet or on your Identification Card.]

[***Specialty Drug Program***
Each time you need a Prescription Order filled for a Covered Drug that has been classified as a Specialty Drug, you may elect to use a BCBSTX Preferred Specialty Drug Provider or a Participating Pharmacy. A list identifying these Specialty Drugs is available by accessing the BCBSTX website at www.bcbstx.com or by contacting the Customer Service helpline number shown in this Benefit Booklet or on your Identification Card. It is important to note that if a Covered Drug is on the Specialty Drug List, the provisions in the subsection entitled ***Preferred Brand Name Drug List*** are inapplicable. The Specialty Drug List will identify Specialty Drugs and will classify them as a Generic Drug or a brand name drug. Your cost will be the appropriate Specialty Drug Copayment Amount indicated on your Schedule of Coverage for each provider plus any pricing differentials that may apply based on the classification status of the Specialty Drug you receive. [You will also be responsible for any Deductible amounts that may apply to your coverage.] You or your prescribing Physician can locate a Preferred Specialty Drug Provider by contacting the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card. Utilizing a Preferred Specialty Drug Provider for your Specialty Drug Prescription Order will usually be your most cost effective option.]

[***Preferred Brand Name Drug List***
A Preferred Brand Name Drug is subject to the Preferred Brand Name Drug Copayment Amount plus any pricing differences that may apply to the Covered Drug you receive. These drugs are identified on the *Preferred Brand Name Drug List* that is maintained by the Carrier. This list is developed using monographs written by the American Medical Association, Academy of Managed Care Pharmacies, and other Pharmacy and medical related organizations, describing clinical outcomes, drug efficacy, and side effect profiles.

BCBSTX will routinely review the *Preferred Brand Name Drug List* and periodically adjust it to modify the Preferred or Non-Preferred Brand Name Drug status of existing or new drugs. Changes to this list will be implemented on the Employer's Contract Anniversary. The *Preferred Brand Name Drug List* and any modifications will be made available to Participants. Participants may access our website at www.bcbstx.com or call the Customer Service Helpline at the telephone number shown in this Benefit Booklet or on your Identification Card to determine if a particular drug is on the *Preferred Brand Name Drug List*. Drugs that do not appear on the *Preferred Brand Name Drug List* may be subject to the Non-Preferred Brand Name Drug Copayment Amount plus any pricing differences that may apply to the Covered Drug you receive.]

Injectable Drugs
Injectable drugs for subcutaneous self-administration are also covered under the Plan. You are responsible for any [Prescription Drug Deductibles,] [Copayment Amounts] [Coinsurance Amounts], and pricing differences that may apply to the Covered Drug dispensed. Injectable drugs include, but are not limited to, insulin and Imitrex.

The day supply of disposable syringes and needles you will need for self-administered injections will be limited on each occasion dispensed to amounts appropriate to the dosage amounts of covered injectable drugs actually prescribed and dispensed, but cannot exceed 100 syringes and needles per Prescription Order in a 30-day period.

[*Diabetes Supplies [and Blood Glucose Monitors] for Treatment of Diabetes*
Benefits are available for Medically Necessary items of Diabetes Supplies [and blood glucose monitors (including non-invasive monitors and monitors for the blind)] for which a Physician or authorized Professional Other Provider has written an order. Such Diabetes Supplies, when obtained for a Qualified Participant (for more information regarding Qualified Participant, refer to the ***Benefits for Treatment of Diabetes*** section of the medical portion of this Benefit Booklet), shall include but not be limited to the following:

- [Test strips specified for use with a corresponding blood glucose monitor]
- [Lancets and lancet devices]
- [Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein]
- [Insulin and insulin analog preparations]
- [Injection aids, including devices used to assist with insulin injection and needleless systems]
- [Insulin syringes]
- [Biohazard disposable containers]
- [Prescriptive and non-prescriptive oral agents for controlling blood sugar levels,] [and]
- [Glucagon emergency kits]

You are responsible for any [Prescription Drug Deductibles], [Calendar Year Deductibles], [Copayment Amounts] [Coinsurance Amounts], and any pricing differences that may apply to the items dispensed.]

[***Prior Authorizations***
To ensure that a drug is safe, effective, and part of a specific treatment plan, certain medications may require prior authorization and the evaluation of additional clinical information before dispensing. A list of the medications which require prior authorization is available to you on our website at www.bcbstx.com.

When you present a Prescription Order to a Participating Pharmacy [or] [through the Mail Service Pharmacy] [or] [through Preferred Specialty Drug Providers] for one of these designated medications, your Physician or authorized Professional Other Provider will be required to submit a *Prior Authorization Request* form on your behalf before the medication can be dispensed.

This form may also be submitted by your Physician or authorized Professional Other Provider in advance of the request to the Pharmacy. The Physician or authorized Professional Other Provider can obtain the *Prior Authorization Request* form by accessing our website at www.bcbstx.com. The requested medication may be approved or denied based upon its accordance with established clinical criteria.

Non-Participating Pharmacies cannot access the criteria for prior authorizations online. It is important to contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card prior to using one of these Pharmacies since Prescription Orders obtained through a Non-Participating Pharmacy may be denied for reimbursement based upon this criteria.]

[***Step Therapy***
To ensure that a drug is Medically Necessary and part of a specific treatment plan, designated drugs may require the utilization of acceptable alternative medications prior to dispensing. A list of the medications which require

alternative steps to be taken before the requested Prescription Order can be filled is available to you on our website at www.bcbstx.com.

When you submit a Prescription Order to a Participating Pharmacy [or] [through the Mail Service Pharmacy] [or] [through Preferred Specialty Drug Providers] for one of these designated medications, the Pharmacist will review your online prescription history and determine if any acceptable alternatives are required before filling the Prescription Order. If so, he will direct you to contact your Physician or authorized Professional Other Provider to obtain an acceptable alternative Prescription Order or to discuss possible over the counter solutions. Acceptable alternatives can be Legend Drugs or over the counter medications which may or may not be in the same therapeutic category.

Non-Participating Pharmacies cannot access the criteria for step therapy online. It is important to contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card prior to using one of these Pharmacies since Prescription Orders obtained through a Non-Participating Pharmacy may be denied for reimbursement based upon this criteria.]

Limitations on Quantities Dispensed – Day Supply

[Benefits for Covered Drugs obtained from a Participating Pharmacy, [or] a Non-Participating Pharmacy, [or] [through the Mail Service Pharmacy] [or] [through Preferred Specialty Drug Providers] are provided up to the maximum day supply limit indicated on your Schedule of Coverage. The [Coinsurance Amount] [Copayment Amount] applicable for the designated day supply of dispensed drugs for retail Pharmacies [and] [through the Mail Service Pharmacy] [and] [through Preferred Specialty Drug Providers] [are] [is] also indicated on your Schedule of Coverage.]

[If a Prescription Order is written for a certain quantity of medication to be taken in a time period directed by a Physician or an authorized Other Professional Provider, the Prescription Order will only be covered for a clinically appropriate pre-determined quantity of medication for the specified amount of time. To determine if a specific drug is subject to this limitation, contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card.

The day supply of a given prescription drug indicates the number of units to be dispensed and is determined based on pertinent medical information and clinical efficacy and safety. Quantities of some drugs are restricted regardless of the quantity ordered by the Physician or authorized Professional Other Provider. The Carrier has the right to determine the day supply at its sole discretion.

Payment for benefits covered under this Plan **may be denied** if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation.

Participants requiring Prescription Orders in excess of the day supply limit established by BCBSTX may ask their Physician or authorized Professional Other Provider to submit a request for clinical review on their behalf. The Physician or authorized Professional Other Provider can obtain the *Quantity Limit Override Request* form by accessing our website at www.bcbstx.com. Any pertinent medical information along with the completed form should be faxed to Clinical Pharmacy Programs at the fax number indicated on the form. The request will be approved or denied after evaluation of the submitted clinical information.]

[***Right of Appeal***

In the event that a requested Prescription Order is still denied on the basis of [prior authorization criteria,][step therapy criteria,[or] [a day supply limit] after your Physician or authorized Professional Other Provider has submitted clinical documentation, you have the right to appeal as indicated under the **Review of Claim Determinations** section of this Benefit Booklet.]

[Deductibles,] [Maximums,] [and] Copayment Amounts

[***Prescription Drug Deductible***
The Prescription Drug Deductible shown on your Schedule of Coverage is the dollar amount of Covered Drug expenses that must be satisfied by each Participant each Calendar Year before benefits under the Prescription Drug Program will be available. The Prescription Drug Deductible will apply to Covered Drugs obtained through retail Pharmacies [and][,] [through the Mail Service Prescription Drug Program] [and through Preferred Specialty Drug Providers]. After the Prescription Drug Deductible is met, the Participant will pay the appropriate Copayment Amount and any pricing differences that may apply to the Covered Drug you receive.

Whether you use a Participating Pharmacy, [or] a Non-Participating Pharmacy, [or][,] [the Mail Service Prescription Drug Program] [or a Preferred Specialty Drug Provider,] the Allowable Amount of your Covered Drug expenses will be applied toward satisfaction of your Prescription Drug Deductible.

After each Participant has satisfied his Prescription Drug Deductible, that Participant will pay the appropriate Copayment Amount (and any pricing difference) for each Prescription Order filled or refilled for the remainder of the Calendar Year.

The pharmacist [or the Preferred Specialty Drug Provider] can tell you once the Prescription Drug Deductible has been satisfied or you may contact the Customer Service Helpline.]

[***Prescription Drug Calendar Year Maximum***
The Prescription Drug Calendar Year Maximum shown on your Schedule of Coverage is the total amount of benefits available under the Prescription Drug Program for a Calendar Year. The Calendar Year maximum will apply to each Participant separately and will include all payments made under the Prescription Drug Program; whether through a Participating Pharmacy, [or] a Non-Participating Pharmacy, [or][,] [under the Mail Service Prescription Drug Program] [or a Preferred Specialty Drug Provider].

Once a Participant has reached the Prescription Drug Calendar Year Maximum, no additional benefits for Covered Drugs will be available until the next Calendar Year benefit period begins.]

Copayment Amounts
Copayment Amounts for a Participating Pharmacy [or] Non-Participating Pharmacy [or][,] [the Mail Service Prescription Drug Program] [or a Preferred Specialty Drug Provider] are shown on your Schedule of Coverage. The amount you pay depends on the Covered Drug dispensed. If the Covered Drug dispensed is a:

[1.] Generic Drug - You pay the Generic Drug Copayment Amount

[2.] [Brand Name Drug - You pay the Brand Name Drug Copayment Amount]

[3.] [Preferred Brand Name Drug – You pay the Preferred Brand Name Drug Copayment Amount]

[4.] [Non-Preferred Brand Name Drug – You pay the Non-Preferred Brand Name Drug Copayment Amount]

[5.] [Specialty Drug – You pay the Specialty Drug Copayment Amount]

If the Allowable Amount of the Covered Drug is less than the Copayment Amount, the Participant will pay the lower cost.

[How Copayment Amounts Apply
When your Physician has marked the Prescription Order "Brand Necessary" or "Brand Medically Necessary," the pharmacist may only dispense the brand name drug and you pay the appropriate Brand Name Drug Copayment Amount.

If the Physician has not stipulated a dispensing directive prohibiting substitution of a generic equivalent (Brand Necessary or Brand Medically Necessary), you may still choose to buy the brand name drug instead of the Generic Drug.

Your payment amount will be the sum of:

(a) the Brand Name Drug Copayment Amount, **plus**
(b) the difference between the Allowable Amount of the Generic Drug and the Allowable Amount of the brand name drug.]

[***How Brand Name Drug Pricing Difference Applies***
If there is no Generic Drug for your brand name drug Prescription Order, you will pay no more than the Brand Name Drug Copayment Amount. If you receive a brand name drug when a Generic Drug is available, your payment amount will be the sum of:

(a) the difference between the Allowable Amount of the brand name drug and the Allowable Amount of the Generic Drug, **plus**
(b) the Brand Name Drug Copayment Amount.]

[How Copayment Amounts Apply
When your Physician has marked the Prescription Order "Brand Necessary" or "Brand Medically Necessary," the pharmacist may only dispense the brand name drug and you pay the appropriate brand name Drug Copayment Amount.

If the Physician has not stipulated a dispensing directive prohibiting substitution of a generic equivalent (Brand Necessary or Brand Medically Necessary), you may still choose to buy the brand name drug instead of the Generic Drug.

If the brand name drug dispensed is on the *Preferred Brand Name Drug List*, your payment amount will be the sum of:

(a) the Preferred Brand Name Drug Copayment Amount, **plus**
(b) the difference between the Allowable Amount of the Generic Drug and the Allowable Amount of the Preferred Brand Name Drug.

If the brand name drug dispensed is a Non-Preferred Brand Name Drug, your payment amount will be the sum of:

(a) the Preferred Brand Name Drug Copayment Amount, plus
(b) the difference between the Allowable Amount of the Generic Drug and the Allowable Amount of the Non-Preferred Brand Name Drug.]

[How Preferred Brand Name Drug Pricing Difference Applies
If there is no Generic Drug for your Preferred Brand Name Drug Prescription Order, you will pay no more than the applicable Preferred Brand Name Drug Copayment Amount. If you receive a Preferred Brand Name Drug when a Generic Drug is available, your payment amount will be the sum of:

(a) the difference between the Allowable Amount of the Preferred Brand Name Drug and the Allowable Amount of the Generic Drug, **plus**
(b) the Preferred Brand Name Drug Copayment Amount.

If there is no Generic Drug for your Non-Preferred Brand Name Drug Prescription Order, you will pay no more than the applicable Non-Preferred Brand Name Drug Copayment Amount. If you receive a Non-Preferred Brand Name Drug when a Generic Drug is available, your payment amount will be the sum of:

(a) the difference between the Allowable Amount of the Non-Preferred Brand Name Drug and the Allowable Amount of the Generic Drug, **plus**
(b) the Preferred Brand Name Drug Copayment Amount.]

[***How Copayment Amounts Apply – Specialty Drug Program***
For your Specialty Drug Prescription Order, when your Physician has marked the Prescription Order "Brand Necessary" or "Brand Medically Necessary," the pharmacist may only dispense the brand name drug and you pay the appropriate Specialty Drug Copayment Amount.

If the Physician has not stipulated a dispensing directive prohibiting substitution of a generic equivalent (Brand Necessary or Brand Medically Necessary), you may still choose to buy the brand name drug instead of the Generic Drug. Your payment amount will be the sum of:

(a) the difference between the Allowable Amount of the Generic Drug and the Allowable Amount of the brand name drug, **plus**
(b) the Specialty Drug Copayment Amount.]

[***How Brand Name Drug Pricing Difference Applies – Specialty Drug Program***
For your Specialty Drug Prescription Order, if there is no Generic Drug for your brand name drug, you will pay no more than the applicable Specialty Drug Copayment Amount.

If you receive a brand name drug when a Generic Drug is available, your payment amount will be the sum of:

(a) the difference between the Allowable Amount of the Generic Drug and the Allowable Amount of the brand name drug, **plus**
(b) the Specialty Drug Copayment Amount.]

Limitations and Exclusions

The benefits of the Prescription Drug Program are not available for:

1. Drugs which do not by law require a Prescription Order from a Provider (**except** insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels); and drugs or covered devices for which no valid Prescription Order is obtained.

2. Devices [or durable medical equipment] of any type (even though such devices may require a Prescription Order,) such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices (provided that disposable hypodermic needles and syringes for self-administered injections [and those devices listed as Diabetes Supplies] shall be specific exceptions to this exclusion). [NOTE: Coverage for contraceptive devices is provided under the medical portion of this Plan.]

3. Administration or injection of any drugs.

4. [Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is **no** non-prescription alternative).]

5. Drugs dispensed in a Physician's or authorized Professional Other Provider's office or during confinement while a patient is in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.

6. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.

7. Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid), or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that the exclusions of this section shall not be applicable to any coverage held by the Participant for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

8. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery.

9. Covered Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the Participant's cost share determined under this Plan.

10. [Contraceptive devices, non-prescription contraceptive materials, (including prescription contraceptive drugs which are Legend Drugs, unless prescription contraceptive coverage is necessary to preserve the life or health of the Participant).]

11. [Oral and injectable infertility and fertility medications.]

12. [Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.]

13. Drugs required by law to be labeled: "Caution - Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made for the drugs.

14. Drugs dispensed in quantities in excess of the day supply amounts stipulated in your Schedule of Coverage, [certain Covered Drugs exceeding the clinically appropriate predetermined quantity], or refills of any prescriptions in excess of the number of refills specified by the Physician or authorized Professional Other Provider or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.

15. Legend Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.

16. Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.

17. [Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.]

18. Drugs, that the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.

19. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.

20. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your Employer's group health care plan, or for which benefits have been exhausted.

21. [Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.]

22. [Services and supplies for smoking cessation programs and the treatment of nicotine addiction.]

23. Compounded drugs that do not meet the definition of Compound Drugs in this portion of your Benefit Booklet.

24. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.

25. [Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s).]

26. [Retin A or pharmacologically similar topical drugs.]

27. Athletic performance enhancement drugs.

28. [Drugs to treat sexual dysfunction, including, but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine in oral and topical form.]

29. Allergy serum and allergy testing materials.

30. Injectable drugs, except those self-administered subcutaneously [or as may be provided under the Specialty Drug Program].

31. [Benefits for any Prescription Orders in excess of the Prescription Drug Calendar Year Maximum specified on your Schedule of Coverage.]

32. [Prescription Orders which do not meet the required step therapy criteria.]

33. [Prescription Orders which do not meet the required prior authorization criteria.]

Definitions

(In addition to the applicable terms provided in the **DEFINITIONS** *Section of the Benefit Booklet, the following terms will apply specifically to this* **PRESCRIPTION DRUG PROGRAM** *section.)*

Allowable Amount means the maximum amount determined by BCBSTX to be eligible for consideration of payment for a particular Covered Drug.

1. As applied to Participating Pharmacies [and][,] the Mail Service Prescription Drug Program,] [and Preferred Specialty Drug Providers,] the Allowable Amount is based on the provisions of the contract between BCBSTX and the Participating Pharmacy [or Pharmacy for the Mail Service Prescription Drug Program] [or] [the Preferred Specialty Drug Provider] in effect on the date of service.

2. As applied to Non-Participating Pharmacies, the Allowable Amount is based on the Average Wholesale Price.

Average Wholesale Price means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a Pharmacy.

[**Coinsurance Amount** means the dollar amount of Covered Drugs incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan.]

Compound Drugs means those drugs that meet the following requirements:

1. The drugs in the compounded product are Food and Drug Administration (FDA) approved;
2. The approved product has an assigned National Drug Code (NDC); and
3. The primary active ingredient is a Covered Drug under the Prescription Drug Program.

Copayment Amount, with respect to the Prescription Drug Program, means [the dollar amount] [percentage amount] [the dollar amount followed by the percentage amount] paid by the Participant for each Prescription Order filled or refilled through a Participating Pharmacy [or] Non-Participating Pharmacy [or] [through the Mail Service Prescription Drug Program] [or] [through Preferred Specialty Drug Providers].

Covered Drugs means any Legend Drug (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, including disposable syringes and needles needed for self-administration):

1. Which is Medically Necessary and is ordered by a Physician or authorized Professional Other Provider naming a Participant as the recipient;
2. For which a written or verbal Prescription Order is provided by a Physician or authorized Professional Other Provider;
3. For which a separate charge is customarily made;
4. Which is not entirely consumed at the time and place that the Prescription Order is written;
5. For which the U.S. Food and Drug Administration (FDA) has given approval for a particular use or purpose; and
6. Which is dispensed by a Pharmacy and is received by the Participant while covered under the Plan, **except when** received from a Provider's office, or during confinement while a patient in a hospital or other acute care institution or facility (refer to **Limitations and Exclusions**).

Generic Drug means a drug which is approved by the U.S. Food and Drug Administration (FDA) as pharmaceutically and therapeutically equivalent for a particular use or purpose to the brand name drug prescribed.

Legend Drugs means drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution - Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose.

National Drug Code (NDC) means a national classification system for the identification of drugs.

Non-Participating Pharmacy means a retail Pharmacy which has not entered into an agreement to provide prescription drug services to Participants under the Prescription Drug Program.

[**Non-Preferred Brand Name Drug** means a brand name drug which does not appear on the *Preferred Brand Name Drug List.*]

[**Non-Preferred Brand Name Drug Copayment Amount** means the Copayment Amount applicable if a Non-Preferred Brand Name Drug is dispensed.]

Participating Pharmacy means an independent retail Pharmacy or chain of retail Pharmacies which have entered into an agreement to provide prescription drug services to Participants under the Prescription Drug Program.

Pharmacy means a state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he practices.

[**Preferred Brand Name Drug** means a brand name drug which appears on the *Preferred Brand Name Drug List.]*

[**Preferred Brand Name Drug Copayment Amount** means the Copayment Amount applicable if a Preferred Brand Name Drug is dispensed.]

[**Preferred Specialty Drug Providers** mean those providers that have entered into an agreement to provide Specialty Drugs under the Prescription Drug Program portion of your Plan.]

Prescription Order means a written or verbal order from a Physician or authorized Professional Other Provider to a pharmacist for a drug or device to be dispensed. Orders written by Physicians or authorized Professional Other Providers located outside the United States to be dispensed in the United States are not covered under the Plan**.**

[**Specialty Drugs** means those legend drugs that (1) are unique, high-cost medications that may be given by any route of administration,(2) benefit a limited patient population, and (3) typically require complex dispensing technique, delivery procedures, and/or patient education and support.]

[**Specialty Drug Copayment Amount** means the Copayment Amount applicable if a Specialty Drug is dispensed.]

GENERAL PROVISIONS

Agent

The Employer is not the agent of the Carrier.

Amendments

The Plan may be amended or changed at any time by agreement between the Employer and BCBSTX. No notice to or consent by any Participant is necessary to amend or change the Plan.

Assignment and Payment of Benefits

If a written assignment of benefits is made by a Participant to a Provider and the written assignment is delivered to the Carrier with the claim for benefits, the Carrier will make any payment directly to the Provider. Payment to the Provider discharges the Carrier's responsibility to Participant for any benefits available under the Plan.

Conformity with State Statutes

Laws in some states require that certain benefits or provisions be provided to you if you are a resident of that state when the contract that insured you is not issued in your state. Any provision of this Benefit Booklet which, on its effective date, is in conflict with applicable statutes of the state in which the Employee resides on such date, is hereby amended to conform to: (a) the minimum requirements of such statutes, or (b) the benefits or provisions of this Benefit Booklet to the extent they exceed such minimum requirements.

Disclosure Authorization

If you file a claim for benefits, it will be necessary that you authorize any health care Provider, insurance carrier, or other entity to furnish BCBSTX all information and records or copies of records relating to the diagnosis, treatment, or care of any individual included under your coverage. If you file claims for benefits, you and your Dependents will be considered to have waived all requirements forbidding the disclosure of this information and records.

Medicare

Special rules apply when you are covered by this Plan and by Medicare. Generally, the Plan is a Primary Plan if you are an active Employee, and Medicare is a Primary Plan if you are a retired Employee.

Participant/Provider Relationship

The choice of a health care Provider should be made solely by you or your Dependents. BCBSTX does not furnish services or supplies but only makes payment for Eligible Expenses incurred by Participants. BCBSTX is not liable for any act or omission by any health care Provider. BCBSTX does not have any responsibility for a health care Provider's failure or refusal to provide services or supplies to you or your Dependents. Care and treatment received are subject to the rules and regulations of the health care Provider selected and are available only for sickness or injury treatment acceptable to the health care Provider.

BCBSTX, [Network Providers,] and[/or] [other] contracting Providers are independent contractors with respect to each other. BCBSTX in no way controls, influences, or participates in the health care treatment decisions entered into by said Providers. BCBSTX does not furnish medical, surgical, hospitalization, or similar services or supplies, or practice medicine or treat patients. The Providers, their employees, their agents, their ostensible agents, and/or their representatives do not act on behalf of BCBSTX nor are they employees of BCBSTX.

Refund of Benefit Payments

If BCBSTX pays benefits for Eligible Expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error, BCBSTX has the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, BCBSTX may deduct any refund due it from any future benefit payment.

State Government Programs

1. If a Participant under the Plan is also a Medicaid recipient, any benefits for services or supplies under the Plan will not be excluded solely because benefits are paid or payable for such services or supplies under Medicaid. Any benefits available under the Plan will be payable to the Texas Department of Human Services to the extent required by the *Texas Insurance Code*; and

2. All benefits paid on behalf of a child or children under the Plan must be paid to the Texas Department of Human Services where;

    a. The Texas Department of Human Services is paying benefits pursuant to provisions in the *Human Resources Code*; and

    b. The parent who is covered under the Plan has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support; and

    c. The Carrier receives written notice at its Administrative Office affixed to the benefit claim when the claim is first submitted, that the benefits claimed must be paid directly to the Texas Department of Human Services.

Subrogation

If the Carrier pays or provides benefits for you or your Dependents under this Plan, the Carrier is subrogated to all rights of recovery which you or your Dependent have in contract, tort, or otherwise against any person, organization, or insurer for the amount of benefits the Carrier has paid or provided. That means the Carrier may use your rights to recover money through judgment, settlement, or otherwise from any person, organization, or insurer.

For the purposes of this provision, *subrogation* means the substitution of one person or entity (the Carrier) in the place of another (you or your Dependent) with reference to a lawful claim, demand or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

Right of Reimbursement
In jurisdictions where subrogation rights are not recognized, or where subrogation rights are precluded by factual circumstances, the Carrier will have a right of reimbursement.

If you or your Dependent recover money from any person, organization, or insurer for an injury or condition for which the Carrier paid benefits under this Plan, you or your Dependent agree to reimburse the Carrier from the recovered money for the amount of benefits paid or provided by the Carrier. That means you or your Dependent will pay to the Carrier the amount of money recovered by you through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits paid or provided by the Carrier.

Right to Recovery by Subrogation or Reimbursement
You or your Dependent agree to promptly furnish to the Carrier all information which you have concerning your rights of recovery from any person, organization, or insurer and to fully assist and cooperate with the Carrier in protecting and obtaining its reimbursement and subrogation rights. You, your Dependent or your attorney will notify the Carrier before settling any claim or suit so as to enable us to enforce our rights by participating in the settlement of the claim or suit. You or your Dependent further agree not to allow the reimbursement and subrogation rights of the Carrier to be limited or harmed by any acts or failure to act on your part.

Coordination of Benefits

The availability of benefits specified in this Contract is subject to Coordination of Benefits (COB) as described below. This COB provision applies to This Plan when a Participant has health care coverage under more than one Plan.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan shall not be reduced when This Plan determines its benefits before another Plan; but may be reduced when another Plan determines its benefits first.

Coordination of Benefits – Definitions

1. **Plan** means any group insurance or group-type coverage, whether insured or uninsured.
   This includes:
   a. group or blanket insurance;
   b. franchise insurance that terminates upon cessation of employment;
   c. group hospital or medical service plans and other group prepayment coverage;
   d. any coverage under labor-management trustee arrangements, union welfare arrangements, or employer organization arrangements;
   e. governmental plans, or coverage required or provided by law.

   Plan does *not* include:
   a. any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;
   b. a policy of health insurance that is individually underwritten and individually issued;
   c. school accident type coverage; or
   d. a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

   Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

2. **This Plan** means the part of this Contract that provides benefits for health care expenses.

3. **Primary Plan/Secondary Plan**
   The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the Participant. A *Primary Plan* is a Plan whose benefits are determined before those of the other Plan and without considering the other Plan's benefit. A *Secondary Plan* is a Plan whose benefits are determined after those of a Primary Plan and may be reduced because of the other Plan's benefits.

   When there are more than two Plans covering the Participant, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

4. **Allowable Expense** means a necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the Participant for whom claim is made.

5. **Claim Determination Period** means a Calendar Year. However, it does not include any part of a year during which a Participant has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

6. **We** or **Us** means Blue Cross and Blue Shield of Texas

Order of Benefit Determination Rules

1. **General Information**
   a. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless (a) the other Plan has rules coordinating its benefits with those of This Plan, and (b) both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other Plan.

   b. If this Contract contains any dental or vision benefits, the benefits provided by the health portion of this contract will be the Secondary Plan.

2. **Rules**
   This Plan determines its order of benefits using the first of the following rules which applies:

   a. ***Non-Dependent/Dependent.*** The benefits of the Plan which covers the Participant as an Employee, member or subscriber are determined before those of the Plan which covers the Participant as a Dependent. However, if the Participant is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is

      (1) secondary to the Plan covering the Participant as a Dependent and
      (2) primary to the Plan covering the Participant as other than a Dependent (e.g., a retired Employee), then the benefits of the Plan covering the Participant as a Dependent are determined before those of the Plan covering that Participant other than a Dependent.

   b. ***Dependent Child/Parents Not Separated or Divorced.*** Except as stated in Paragraph c below, when This Plan and another Plan cover the same child as a Dependent of different parents:

      (1) The benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year; but

      (2) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

      However, if the other Plan does not have the rule described in this Paragraph b, but instead has a rule based on gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

   c. ***Dependent Child/Parents Separated or Divorced.*** If two or more Plans cover a Participant as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

      (1) First, the Plan of the parent with custody of the child;
      (2) Then, the Plan of the spouse of the parent with custody, if applicable;
      (3) Finally, the Plan of the parent not having custody of the child.

      However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Calendar Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. ***Joint Custody.*** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Paragraph b.

e. ***Active/Inactive Employee.*** The benefits of a Plan which covers a Participant as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that Participant as a laid off or retired Employee. The same would hold true if a Participant is a Dependent of a person covered as a retired Employee and an Employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Paragraph e does not apply.

f. ***Continuation Coverage.*** If a Participant whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following shall be the order of benefit determination:

(1) First, the benefits of a Plan covering the Participant as an Employee, member or subscriber (or as that Participant's Dependent);

(2) Second, the benefits under the continuation coverage.

If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits this Paragraph f does not apply.

g. ***Longer/Shorter Length of Coverage.*** If none of the above rules determine the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that Participant for the shorter period of time.

Effect on the Benefits of This Plan

1. **When This Section Applies**
This section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this section.

2. **Reduction in this Plan's Benefits**
The benefits of This Plan will be reduced when the sum of:

a. The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

b. The benefits that would be payable for the Allowable Expense under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made exceeds those Allowable Expenses in a Claim Determination Period.

In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as previously described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

We assume no obligation to discover the existence of another Plan, or the benefits available under the other Plan, if discovered. We have the right to decide what information we need to apply these COB rules. We may get

needed information from or release information to any other organization or person without telling, or getting the consent of, any person. Each person claiming benefits under This Plan must give us any information concerning the existence of other Plans, the benefits thereof, and any other information needed to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again.

Right to Recovery

If the amount of the payments We make is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. the persons We have paid or for whom We have paid;
2. insurance companies; or
3. Hospitals, Physicians, or Other Providers; or
4. any other person or organization.

Termination of Coverage

BCBSTX is not required to give you prior notice of termination of coverage. BCBSTX will not always know of the events causing termination until after the events have occurred.

Termination of Individual Coverage
Coverage under the Plan for you and/or your Dependents will automatically terminate when:

1. Your portion of the group premium is not received timely by BCBSTX; or
2. You no longer satisfy the definition of an Employee as defined in this Benefit Booklet, including termination of employment; or
3. The Plan is terminated or the Plan is amended, at the direction of the Employer, to terminate the coverage of the class of Employees to which you belong; or
4. A Dependent ceases to be a Dependent as defined in the Plan.

However, when any of these events occur, you and/or your Dependents may be eligible for continued coverage. See **Continuation Privilege** in the **GENERAL PROVISIONS** section of this Benefit Booklet.

The Carrier may refuse to renew the coverage of an eligible Employee or Dependent for fraud or intentional misrepresentation of a material fact by that individual.

Coverage for a child of any age who is medically certified as *Disabled* and dependent on the parent will not terminate upon reaching the limiting age shown in the Schedule of Coverage if the child continues to be both:

1. *Disabled,* and
2. Dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States.

Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered under the Plan and before the child attains the limiting age. You must submit satisfactory proof of the disability and dependency through your Employer to the Carrier within 31 days following the child's attainment of the limiting age. As a condition to the continued coverage of a child as a *Disabled* Dependent beyond the limiting age, the Carrier may require periodic certification of the child's physical or mental condition but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Termination of the Group
The coverage of all Participants will terminate if the group is terminated in accordance with the terms of the Plan.

Extension of Benefits
If this Contract terminates (as described in the Employer's Contract), any Participant who is *Totally Disabled* on the effective date of the termination of the Contract shall be entitled to receive benefits as described in this Benefit Booklet, subject to the benefit limitations and maximums, for the continued treatment of the condition causing the *Total Disability*. Benefits will be available for the period of the *Total Disability* or for 90 days following the termination date of the Contract, whichever is less.

However, if your coverage under the Plan is replaced with coverage issued by a *Succeeding Carrier* which provides substantially equivalent or greater benefits than those provided by this Contract, this extension of benefits for *Total Disability* is not applicable.

Succeeding Carrier means an insurer that has replaced the coverage of BCBSTX with its coverage.

Total Disability or *Totally Disabled* means as applied to:

1. An Employee, the complete inability of the Employee to perform all of the substantial and material duties and functions of his occupation and any other gainful occupation in which the Employee earns substantially the same compensation earned prior to disability; and
2. [A retired Employee, the complete inability of the retired Employee to carry on all of the normal duties or activities of a person in good health who is the same sex and approximate age; and]
3. A Dependent, confinement as a bed patient in a Hospital.

Continuation Privilege

Any Participant whose insurance under the Contract has been terminated for any reason except involuntary termination for cause, including discontinuance of the Contract in its entirety or with respect to an insured class, and, who has been continuously insured under the Contract or any group policy providing similar benefits which it replaces for at least three consecutive months immediately prior to termination shall be entitled to such privilege as outlined below:

Continuation of group coverage must be requested in writing within 31 days following the later of:

1. The date the group coverage would otherwise terminate; or

2. The date the Participant is given notice of the right of continuation by either the Employer or the group Contractholder.

A Participant electing continuation must pay to the Employer or Contractholder, on a monthly basis in advance, the amount of contribution required by the Employer or Contractholder, plus two percent of the group rate for the insurance being continued under the contract on the due date of each payment.

The Participant's written election, together with the first contribution required to establish contributions on a monthly basis in advance, must be given to the Employer or Contractholder within the later of:

1. Thirty-one days of the date coverage would otherwise terminate, or

2. The date the Employee is given the right of continuation by either the Employer or the Contractholder.

Continuation may not terminate until the earliest of:

1. Six months after the date the election is made,

2. The date on which failure to make timely payments would terminate coverage;

3. The date on which the group coverage terminates in its entirety;

4. The date on which the covered person is or could be covered under Medicare;

5. The date on which the covered person is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical subscriber contract or medical practice or other prepayment plan or any other plan or program;

6. The date the covered person is eligible for similar benefits whether or not covered therefor under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

7. Similar benefits are provided or available to such person, pursuant to or in accordance with the requirements of any state or federal law.

Additional Continuation for Certain Dependents - State

If coverage terminates as the result of an Employee's death, retirement, or divorce, a Dependent's coverage can continue. The Dependent must have been covered under the Contract for at least one year, except in the case of a Dependent who is an infant under one year of age. Continuation does not require evidence of insurability.

Continuation under this provision will not apply if continuation is required under the Consolidated Omnibus Budget Reconciliation Act of 1985. In addition, continuation is not available when coverage terminates due to any of these circumstances:

1. The Contract is canceled; or

2. The Dependent fails to make any timely premium payments.

Continuation ends after the earliest of the following:

1. The third anniversary of the severance of the family relationship or the retirement or death of the Subscriber;

2. The insured fails to make premium payments within the time required to make the payments;

3. The insured becomes eligible for substantially similar coverage under another plan or program, including a group health insurance policy or contract, hospital, or medical service subscriber contract, or medical practice or other prepayment plan; or

4. The Contract is canceled.

Notification Requirements
The Dependent must notify the Carrier within 15 days of the Employee's death, retirement, or divorce. The Carrier will immediately provide written notice to the Dependent of the right to continue coverage and will send the election form and instructions for premium payment.

Within 60 days of the Employee's death, retirement, or divorce, the Dependent must give written notice to the Carrier of the desire to exercise the right of continuation or the option expires. Coverage remains in effect during the 60-day period provided premium is paid.

COBRA Continuation - Federal

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Participants may have the right to continue coverage, after the date coverage ends. Participants will not be eligible for COBRA continuation if the Contractholder is exempt from the provisions of COBRA; however, the Participant may be eligible for State Continuation as addressed under **Additional Continuation for Certain Dependents – State.**

Minimum Size of Group
The Group must have normally employed more than twenty (20) employees on a typical business day during the preceding Calendar Year. This refers to the number of full-time and part-time employees employed, not the number of employees covered by a Health Benefit Plan.

Loss of Coverage
If coverage terminates as the result of termination (other than for gross misconduct) or reduction of employment hours, then the Participant may elect to continue coverage for eighteen (18) months from the date coverage would otherwise cease.

A covered Dependent may elect to continue coverage for thirty-six (36) months from the date coverage would otherwise cease if coverage terminates as the result of:

1. divorce from the covered Employee,

2. death of the covered Employee,

3. the covered Employee becomes eligible for Medicare, or

4. a covered Dependent child no longer meets the Dependent eligibility requirements.

COBRA continuation under the contract ends at the earliest of the following events:

1. The last day of the eighteen (18) month period for events which have a maximum continuation period of eighteen (18) months.

2. The last day of the thirty-six (36) month period for events which have a maximum continuation period of thirty-six (36) months.

3. The first day for which timely payment of premium is not made to the Plan with respect to the qualified beneficiary.

4. The date upon which the Employer ceases to provide any group health plan to any Employee.

5. The date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other employer group health benefit plan.

6. The date, after the date of the election, upon which the qualified beneficiary first becomes entitled to Medicare benefits.

Extension of Coverage Period
The eighteen (18) month coverage period may be extended if an event which could otherwise qualify a Participant for the thirty-six (36) month coverage period occurs during the eighteen (18) month period, but in no event may coverage be longer than thirty-six (36) months from the initial qualifying event.

If a Participant is determined to be disabled as defined under the Social Security Act and the Participant notifies the Employer before the end of the initial eighteen (18) month period, coverage may be extended up to an additional eleven (11) months for a total of twenty-nine (29) months. This provision is limited to Participants who are disabled at any time during the first sixty (60) days of COBRA continuation and only if the qualifying event is termination of employment (other than for gross misconduct) or reduction of employment hours.

Notice of COBRA Continuation Rights
The Employer is responsible for providing the necessary notification to Participants as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

For additional information regarding your rights under COBRA continuation, refer to the Continuation Coverage Rights Notice in the **NOTICES** section of this Benefit Booklet.

Information Concerning Employee Retirement Income Security Act Of 1974 (ERISA)

If the Health Benefit Plan is part of an "employee welfare benefits plan" and "welfare plan" as those terms are defined in ERISA:

1. The Employer will furnish summary plan descriptions, annual reports, and summary annual reports to you and other plan participants and to the government as required by ERISA and its regulations.

2. BCBSTX will furnish the Employer with this Benefit Booklet as a description of benefits available under this Health Benefit Plan. Upon written request by the Employer, BCBSTX will send any information which BCBSTX has that will aid the Employer in making its annual reports.

3. Claims for benefits must be made in writing on a timely basis in accordance with the provisions of this Health Benefit Plan. Claim filing and claim review health procedures are found in the **CLAIM FILING AND APPEALS PROCEDURES** section of this Benefit Booklet.

4. BCBSTX is not the ERISA "Plan Administrator" for benefits or activities pertaining to the Health Benefit Plan.

5. This Benefit Booklet is a Certificate of Coverage and not a Summary Plan Description.

6. The Employer has given BCBSTX the authority and discretion to interpret the Health Benefit Plan provisions and to make eligibility and benefit determinations.

AMENDMENTS

NOTICES

NOTICE

Other Blue Cross and Blue Shield Plans Separate Financial Arrangements with Providers

BlueCard

Blue Cross and Blue Shield of Texas hereby informs you that other Blue Cross and Blue Shield Plans outside of Texas ("Host Blues") may have contracts similar to the contracts described above with certain Providers ("Host Blue Providers") in their service areas.

When you access health care services through BlueCard outside of Texas and from a Provider which does not have a contract with Blue Cross and Blue Shield of Texas, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the Host Blue passes on to Blue Cross and Blue Shield of Texas.

To help you understand how this calculation would work, please consider the following example:

a. Suppose you receive covered medical services for an illness while you are on vacation outside of Texas. You show your identification card to the provider to let him or her know that you are covered by Blue Cross and Blue Shield of Texas.

b. The provider has negotiated with the Host Blue a price of $80, even though the provider's standard charge for this service is $100. In this example, the provider bills the Host Blue $100.

c. The Host Blue, in turn, forwards the claim to Blue Cross and Blue Shield of Texas and indicates that the negotiated price for the Covered Service is $80. Blue Cross and Blue Shield of Texas would then base the amount you must pay for the service – the amount applied to your deductible, if any, and your Coinsurance percentage – on the $80 negotiated price, not the $100 billed charge.

d. So, for example, if your Coinsurance is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a Covered Service.

PLEASE NOTE: The coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no Copayments associated with the service rendered. Your deductible(s), Coinsurance and Copayment(s) are specified in this Certificate.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that takes into consideration the actual price increased or reduced to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be charged as a billed charge reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, Blue Cross and Blue Shield of Texas would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided in your health plan insured by Blue Cross and Blue Shield of Texas. This notice is required by legislation to be provided to you. *If you have questions regarding this notice, call Blue Cross and Blue Shield of Texas at 1-800-521-2227 or write us at P.O. Box 660044, Dallas, Texas 75266-0044.*

Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

a. 48 hours following a mastectomy; and
b. 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

a. All stages of the reconstruction of the breast on which mastectomy has been performed;
b. Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
c. Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician.

Deductibles, coinsurance and copayment amounts will be the same as those applied to other similarly covered Inpatient Hospital Expense or Medical-Surgical Expense, as shown on the Schedule of Coverage.

Prohibitions: We may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

NOTICE OF CERTAIN MANDATORY BENEFITS

Examinations for Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

a. A physical examination for the detection of prostate cancer; and

b. A prostate-specific antigen test for each covered male who is:

   (1) At least 50 years of age; or
   (2) At least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

Inpatient Stay Following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

a. 48 hours following an uncomplicated vaginal delivery; and
b. 96 hours following an uncomplicated delivery by Cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to:

a. Give birth in a hospital or other health care facility; or
b. Remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriately licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Prohibitions: We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (e) penalize a physician for recommending inpatient care for the mother or the newborn child.

Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of:

a. A fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years, or
b. A colonoscopy performed every ten years.

Coverage of Tests for Detection of Human Papillomavirus and Cervical Cancer

Coverage is provided, for each woman enrolled in the plan who is 18 years of age or older, for expenses incurred for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage required under this section includes at a minimum a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug and Drug Administration for the detection of the human pappillomavirus.

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

INTRODUCTION

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it**.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18–month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

Blue Cross and Blue Shield of Texas

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Our Responsibilities

We are required by applicable federal and state law to maintain the privacy of your protected health information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all PHI that we maintain, including PHI we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We use and disclose PHI about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures that we are permitted to make.

Treatment: We may use or disclose your PHI to a physician or other health care provider providing treatment to you. We may use or disclose your PHI to a health care provider so that we can make prior authorization decisions under your benefit plan.

Payment: We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include processing claims, determining eligibility or coverage for claims, issuing premium billings, reviewing services for medical necessity, and performing utilization review of claims.

Health Care Operations: We may use and disclose your PHI in connection with our health care operations. Health care operations include the business functions conducted by a health insurer. These activities may include providing customer services, responding to complaints and appeals from members, providing case management and care coordination under the benefit plans, conducting medical review of claims and other quality assessment and improvement activities, establishing premium rates and underwriting rules. In certain instances, we may also provide PHI to the plan sponsor of a group health plan. We may also in our health care operations disclose PHI to business associates[1] with whom we have written agreements containing terms to protect the privacy of your PHI.

We may disclose your PHI to another entity that is subject to the federal Privacy Rules and that has a relationship with you for its health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, case management and care coordination, or detecting or preventing health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your PHI or to disclose it to another person and for the purpose you designate. If you give us an authorization, you may withdraw it in writing at any time. Your withdrawal will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this notice.

We will make disclosures of any psychotherapy notes we may have only if you provide us with a specific written authorization or when disclosure is required by law.

Personal Representatives: We will disclose your PHI to your personal representative when the personal representative has been properly designated by you and the existence of your personal representative is documented to us in writing through a written authorization.

Disaster Relief: We may use or disclose your PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Health Related Services: We may use your PHI to contact you with information about health-related benefits and services or about treatment alternatives that may be of interest to you. We may disclose your PHI to a business associate to assist us in these activities.

We may use or disclose your PHI to encourage you to purchase or use a product or service by face-to-face communication or to provide you with promotional gifts.

Public Benefit: We may use or disclose your PHI as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, certain Food and Drug Administration (FDA) oversight purposes with respect to an FDA-regulated product or activity, and to employers regarding work-related illness or injury required under the Occupational Safety and Health Act (OSHA) or other similar laws;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to avert a serious threat to health or safety;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by and to the extent necessary to comply with state worker's compensation laws.

We will make disclosures for the following public interest purposes, only if you provide us with a written authorization or when disclosure is required by law:

- to coroners, medical examiners, and funeral directors;
- to an organ procurement organization; and
- in connection with certain research activities.

Use and Disclosure of Certain Types of Medical Information: For certain types of PHI we may be required to protect your privacy in ways more strict than we have discussed in this notice. We must abide by the following rules for our use or disclosure of certain types of your PHI:

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1 A "business associate" is a person or entity who performs or assists BCBSTX with an activity involving the use or disclosure of medical information that is protected under the Privacy Rules.

- *Communicable Disease Test Results*. We may not disclose the result of any communicable disease test, unless the disclosure is required by law or the disclosure is to you, your personal representative, a physician or other person who ordered the test, or a health care worker who has a legitimate need to know the results of the test for safety purposes, or pursuant to an authorization signed by you.

- *HIV Test Results*. We may not disclose the result of any HIV test unless required by law or the disclosure is to you, your personal representative, a physician or other person who ordered the test, or a health care worker who has a legitimate need to know the results of the test for safety purposes; or pursuant to an authorization signed by you providing us permission to disclose to an insurance medical information exchange, a reinsurer, or to our attorneys.

- *Genetic Information*. We may not disclose genetic information unless the disclosure is authorized under state or federal criminal law and the disclosure relates to identifying an individual in the course of a criminal or judicial proceeding; is required under specific order of a state or federal court; is authorized under state or federal law to establish paternity; is made to a blood relative of a decedent for purposes of medical diagnosis; or is made to identify a decedent.

- *Status as Victim of Family Violence*. We may not disclose your status as a victim of family violence unless the disclosure is to you; to a physician or health care provider for the provision of health care services; to a licensed physician designated by you; as required by law or pursuant to an order of the Texas Insurance Commissioner or a court order; to our attorneys; or when necessary for our payment and health care operations if to a reinsurer, a party to a sale of all or part of our business or to medical and claims personnel we contract with, providing we cannot without undue hardship first segregate the medical information in a way that does not disclose your status as a victim of family violence.

- *Mental Health Information*. We may not disclose your mental health information except for the same purposes for which we received the information or as may be required by law.

- *Confidential Communications from a Physician*. We may not disclose confidential information about you that we receive from a physician for any purpose other than for which we received the information or as may be required by law.

- *Medical Information Maintained by Our HMO*. Your medical information that is maintained by our HMO may only be disclosed for the HMO's payment and health care operations purposes or as allowed by Texas law pertaining to HMOs.

- *Medical Information We Receive While Performing Utilization Review.* If we collect or receive your medical information while performing utilization review activities, we may not disclose that information unless the disclosure is required by law or to an individual or entity that we have contracted with to aide us in performing utilization review.

Individual Rights

You may contact us using the information at the end of this notice to obtain the forms described here, explanations on how to submit a request, or other additional information.

Access: You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. A "designated record set" contains records we maintain such as enrollment, claims processing, and case management records. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so**.** You must make a request in writing to obtain access to your PHI and may obtain a request form from us. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.

Disclosure Accounting: You have the right to receive a list of instances since April 14, 2003 in which we or our business associates disclosed your PHI for purposes, other than treatment, payment, health care operations, or as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fee structure at your request.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is in writing.

Confidential Communication: You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. You must make your request in writing. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the basis for your request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable, specifies the alternative means or location, and provides satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right, with limited exceptions, to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended and the originator remains available or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be attached to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Right to Receive a Copy of the Notice: You may request a copy of our notice at any time by contacting the Privacy Office or by using our website, www.bcbstx.com. If you receive this notice on our web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the notice.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services; see information at its website: www.hhs.gov. If you request, we will provide you with the address to file your complaint with the U.S. Department of Health and Human Services.

We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact : Director, Privacy Office

Telephone: 1-800-607-7418

Address: P.O. Box 804836; Chicago, IL 60680-4110

RIDER FOR RESIDENTS OF THE STATE OF ARKANSAS

If you reside permanently in the state of Arkansas, the [Certificate][Benefit Booklet] to which this Rider is attached and becomes a part is amended as stated below to conform to the requirements of the state of Arkansas. In the event of a conflict between the [Certificate][Benefit Booklet] and this Rider, the provisions resulting in greater [benefits][Benefits] will be in effect.

1. **Individual and Family Eligibility**

   The eligibility provision outlining a change in coverage from [individual coverage][Individual Coverage][Single Coverage] to [family coverage][Family Coverage] is changed as follows:

   If you apply for a change from [individual coverage][Individual Coverage][Single Coverage] to [family coverage][Family Coverage] within 90 days of the birth or within 60 days of the adoption or [placement for adoption][Placement for Adoption] of a [child][Child], your [family coverage][Family Coverage] will be effective from the date of the birth, adoption or [placement for adoption][Placement for Adoption].

   If you do not apply for [family coverage][Family Coverage] within 90 days of the birth or within 60 days of the adoption or [placement for adoption][Placement for Adoption] of a [child][Child], you can make application at any time. Your [dependents][Dependents] will be subject to the [preexisting condition waiting period][Preexisting Condition Waiting Period] outlined in the [Certificate][Benefit Booklet] to which this Rider is attached. The change will be effective on a date that has been mutually agreed to by your [Employer][Group] and [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma].

2. **Family Coverage**

   The eligibility provision concerning adding [dependents][Dependents] to [family coverage][Family Coverage] is changed as follows**:**

   If you apply to add your newborn [child][Child] to your [family coverage][Family Coverage] within 90 days of the [child's][Child's] birth or to add your adopted [child][Child] or [child][Child] placed for adoption to your [family coverage][Family Coverage] within 60 days of the adoption or [placement for adoption][Placement for Adoption], coverage for your [dependent][Dependent]will be effective from the date of the birth, adoption or [placement for adoption][Placement for Adoption].

   If you do not apply to add your newborn within 90 days of the birth, or your adopted [child][Child] within 60 days of the adoption or [placement for adoption][Placement for Adoption], you can make application at any time. Your [dependents][Dependents]will be subject to the [preexisting

condition waiting period][Preexisting Condition Waiting Period] outlined in the [Certificate][Benefit Booklet] to which this Rider is attached. The change will be effective on a date that has been mutually agreed to by your [Employer][Group] and [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma].

3. Providers

Benefits for the following Providers will be paid at the same level as other Providers.

- [Advanced practice nurses][Advanced Practice Nurses].
- Athletic trainers.
- [Audiologists][Licensed Audiologists].
- Certified orthotists.
- [Chiropractors][Doctors of Chiropractic].
- Community mental health centers or clinics.
- [Dentists][Doctors of Dentistry]
- [Coordinated Home Care][Home Health Care][home health care].
- Hospice care.
- Hospital–based service.
- Hospitals.
- Licensed ambulatory surgery centers.
- Licensed [social workers][Clinical Social Workers].
- Licensed [dieticians][Dieticians].
- Licensed [professional counselors][Professional Counselors].
- Licensed psychological examiners.
- Long–term care facilities
- Nurse Anesthetists
- [Occupational therapists][Licensed Occupational Therapists][Occupational Therapists].
- Optometrists.
- Pharmacists.
- [Physical therapists][Licensed Physical Therapists][Physical Therapists].

- Physicians and surgeons (M.D. and D.O.).
- [Podiatrists][Doctors of Podiatry].
- Prostheticists.
- [Psychologists][Doctors of Psychology].
- Respiratory therapists.
- Rural health clinics; and
- [Speech pathologists][Licensed Speech–Language Pathologists].

4. [Speech Therapy

The [speech therapy][Speech Therapy] benefit is revised to delete the [Benefit Period][benefit period] maximum.]

5. Well Child Care

Benefits will be provided for [Eligible Expenses][Eligible Charges][Covered Charges][Allowable Charge] rendered by a Physician to [children][Children] under age 19, even though they are not ill. Benefits will be limited to the following services:

- Immunizations;
- Routine diagnostic tests;
- 20 physical examinations at approximately the following age intervals:
    - Birth,
    - Two weeks,
    - Two months,
    - Four months,
    - Six months,
    - Nine months,
    - 12 months,
    - 15 months,
    - 18 months,
    - Two years,
    - Three years,
    - Four years,
    - Five years,

- Six years,
- Eight years,
- 10 years,
- 12 years,
- 14 years,
- 16 years, and
- 18 years.

Benefits for immunizations will not be subject to any [copayment][Copayment], [deductible][Deductible], [coinsurance][Coinsurance] or [benefit period][Benefit Period] dollar maximum.

6. Phenylketonuria Treatment

Benefits will be provided for amino acid modified preparations, low protein modified food products and any other special dietary products and formulas prescribed by a Physician for the therapeutic treatment of phenylketonuria.

7. Musculoskeletal Disorders

Benefits will be provided for the surgical and non–surgical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head including [Temporomandibular Joint Dysfunction][temporomandibular joint disorder][Temporomandibular Joint Syndrome][temporomandibular joint dysfunction] and craniomandibular disorder. Your [benefits][Benefits] for musculoskeletal disorders are the same as your [benefits][Benefits] for any other condition.

8. Speech and Hearing

Benefits will be provided for the treatment of loss or impairment of speech or hearing by a speech pathologist or audiologist subject to the same limits, [deductibles][Deductibles] and [coinsurance][Coinsurance] as other [covered services][Covered Services].

9. In Vitro Fertilization

Benefits will be provided for in vitro fertilization procedures for you or your [dependent][Dependent] spouse when:

- Your or your spouse's oocytes are fertilized with the sperm of you or your spouse, and
- You or your spouse have a history of unexplained infertility of at least two years duration; or
- The infertility is associated with one or more of the following medical conditions:

- Endometriosis;
- Exposure in utero to diethylstilbestrol, commonly known as DES;
- Blockage of or removal of one or both fallopian tubes that is not a result of voluntary sterilization; or
- Abnormal male factors contributing to the infertility.

- The in vitro fertilization procedures are performed at a [facility][Facility] licensed or certified by the Arkansas Department of Health which conforms to the standards of the American College of Obstetricians and Gynecologists', or are performed at a [facility][Facility] certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization.
- You or your spouse has been unable to obtain successful pregnancy through any less costly infertility treatment for which coverage is available under the [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan].

The [benefits][Benefits] for in vitro fertilization are the same as the [benefits][Benefits] provided under maternity benefit provisions. Cryopreservation, the procedure whereby embryos are frozen for late implantation, is included as an in vitro fertilization procedure.

10. Maternity Care

The coverage for [Maternity Services][Maternity Care][maternity care] is changed to allow [routine nursery care][Routine Nursery Care] and pediatric charges for a well newborn [child][Child] for up to five full days in a Hospital nursery or until the mother is discharged from the Hospital following the birth.

11. Cancer Treatment

Benefits will be provided for drugs used for the treatment of cancer if:

- The drug has been approved by the federal Food and Drug Administration for the treatment of the specific type of cancer for which it has been prescribed; and
- The drug is recognized for treatment of that specific type of cancer in one of the standard reference compendia or in the medical literature.

12. Mammograms

Benefits will be provided for mammograms as follows:

- A base line mammogram for a female who is at least thirty–five years of age but less than forty years of age;

- One mammogram every one to two years for a female who is from 40 to 49 years of age; and
- One mammogram a year for a female who is at least fifty years of age; or
- A mammogram upon recommendation of a woman's Physician, without regard to age, when the woman has had a prior history of breast cancer or when the woman's mother or sister has had a history of breast cancer.

13. Colorectal Cancer

Benefits will be provided for colorectal cancer examinations as follows:

- If you are more than 50 years of age;
- If you are age 50 and under and are at high risk for colorectal cancer according to the American Cancer Society colorectal cancer screening guidelines; or
- If you are experiencing bleeding from the rectum or blood in the stool, or if you have a change in bowel habits such as diarrhea, constipation or narrowing of the stool that lasts for more than five days.

14. Anesthesia and Dental Procedures

Benefits will be provided for anesthesia, [hospital][Hospital] or [ambulatory surgical facility][Ambulatory Surgical Facility] charges for dental procedures if it is certified that general anesthesia is required to safely perform the procedures and the patient is:

- A [child][Child] under seven years of age who is determined by two licensed [dentists][Dentists] to require without delay necessary dental treatment in a [hospital][Hospital] or [ambulatory surgical facility][Ambulatory Surgical Facility] for a significantly complex dental condition;
- A person with a diagnosed serious physical condition or [Mental Illness][Mental Health Care disorder][Mental Health Disorder]; or
- A person with a significant behavioral problem as determined by the [member's][Member's] Physician.

Immunizations are exempt from any [copayment][Copayment], [coinsurance][Coinsurance], deductible[Deductible] or dollar limit.

15. [Mental Illness][Mental Health Care][Mental Health] and [Substance Abuse Rehabilitation][Chemical Dependency][Drug Abuse and Alcoholism]

The benefit maximums for the [inpatient][Inpatient] and [outpatient][Outpatient] treatment of [Mental Illness][Mental Health Care][Mental Health Disorders] do not apply.

Your [benefits][Benefits] for [inpatient][Inpatient] and [outpatient][Outpatient] [Substance Abuse Rehabilitation][treatment of Chemical Dependency][treatment of drug abuse and alcoholism] are limited to a combined maximum of $6,000 each 24 month period. No more than $3,000 shall be provided in any 30 consecutive day period.

A combined lifetime maximum of $12,000 will apply to [benefits][Benefits] for [inpatient][Inpatient] and [outpatient][Outpatient] [Substance Abuse Rehabilitation][treatment of Chemical Dependency][treatment of drug abuse and alcoholism].

16. Late Claim Payments

The interest rate for a [claim][Claim] not paid on time by the claim administrator is 12%.

17. Continuation of Coverage

If you have been insured continuously under this [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan] for at least three months and your coverage has been terminated for any reason other than nonpayment of the required contribution, you may continue coverage under this [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan] for an additional three months. You must request continuation in writing no later than 10 days after the termination of employment or membership or a change in marital status. You must pay the entire premium including any portion paid by your former [employer][Employer]. Continuation of coverage is subject to the [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan] or a successor [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan] remaining in force.

Continuation of coverage shall end at the earliest of the following dates:

- 120 days after continuation of coverage begins;
- The end of the period for which the individual made a timely contribution;
- The contribution due date following the date the individual becomes eligible for Medicare; or
- The date on which the [policy][contract] is terminated or the [group][Group] withdraws from the [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan].[

18. Conversion Privilege

If your coverage under this [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan] should terminate for any reason, including the discontinuance of the [group policy][Group Policy] in its entirety, and you want to continue [Blue Cross and Blue

Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] coverage with no interruption, you may do so if your [Employer][Group] has not cancelled this coverage and replaced it with other coverage. Here is what to do:

1. Tell [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] or your group administrator that you wish to continue your coverage and you will be provided with the necessary application.
2. Send the application and first premium to [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] within 31 days of the date you leave your [Employer][Group] or within 15 days after you have been given written notice of the conversion privilege, but in no event later than 60 days after you leave your [Employer][Group].

Having done so, you will then be covered by [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] on an individual "direct pay" basis. This coverage will be effective from the date your coverage under this [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan] terminates so long as the premiums charged for the direct pay coverage are paid when due.

These direct pay benefits (and the premium charged for them) may not be exactly the same as the benefits under the [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan]. However, by converting your coverage, your benefits under the [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan] are not interrupted and you will not have to repeat waiting periods (if any).

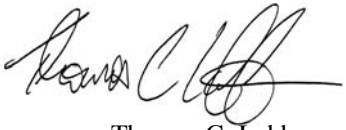
[Should any or all of your [dependents][Dependents] become ineligible for coverage under this [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan], they may convert to direct pay coverage by following the instructions stated above.]]

Except as amended by this Rider, all terms, conditions, limitations and exclusions of the [Certificate][Benefit Booklet] to which this Rider is attached will remain in full force and effect.

[Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)
(Blue Cross and Blue Shield of Texas)
(Blue Cross and Blue Shield of New Mexico)
(Blue Cross and Blue Shield of Oklahoma)

Raymond F. McCaskey
President



Thomas C. Lubben
Secretary]

SERFF Tracking Number:	*CMPL-125649032*	*State:*	*Arkansas*
Filing Company:	*Health Care Service Corporation*	*State Tracking Number:*	*39016*
Company Tracking Number:	*HCSC ET BCBSTX*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*HCSC ET BCBSTX*		
Project Name/Number:	*HCSC ET BCBSTX/HCSC ET BCBSTX*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CMPL-125649032*	*State:*	*Arkansas*
Filing Company:	*Health Care Service Corporation*	*State Tracking Number:*	*39016*
Company Tracking Number:	*HCSC ET BCBSTX*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*HCSC ET BCBSTX*		
Project Name/Number:	*HCSC ET BCBSTX/HCSC ET BCBSTX*		

Supporting Document Schedules

Satisfied -Name: Certification/Notice
Review Status: Approved-Closed 06/03/2008
Comments:
Attachment:
AR_AR Certif of Compliance with Rule 19.pdf

Bypassed -Name: Application
Review Status: Approved-Closed 06/03/2008
Bypass Reason: No policy is being submitted with this filing.
Comments:

Satisfied -Name: Readability
Review Status: Approved-Closed 06/03/2008
Comments:
Attachment:
BCBSTX Readability Certification.pdf

Satisfied -Name: Authorization
Review Status: Approved-Closed 06/03/2008
Comments:
Attachment:
HCSC Authorization to File.pdf

Satisfied -Name: 5-27-2008 Certification
Review Status: Approved-Closed 06/03/2008
Comments:
Attachment:
AR BCBSTX Certification of Benefit Differential.pdf

Insurer: Health Care Service Corporation, a Mutual Legal Reserve Company

Form Number(s): COC-CB-LG-0707
ETGB-AR-HCSC-07

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

Signature of Company Officer

Scott Hilgeman
Name

Vice President and Chief Underwriter

Title

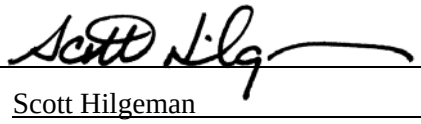
May 2, 2008
Date

Health Care Service Corporation
300 E. Randolph Street
Chicago, IL 60601

READABILITY CERTIFICATION

To the best of our knowledge and ability we have determined the Flesch scale analysis readability test scores to be as shown:

Form Number	Flesch Score
COC-CB-LG-0707	42.0
ETGB-AR-HCSC – 07	40.0

By: 

Scott Hilgeman

Title: Vice President and Chief Underwriter

BlueCross BlueShield of Illinois

NAIC Company Code: 70670

Re: Group Medical Forms

To: All State Insurance Departments

Health Care Service Corporation, a Mutual Legal Reserve Company, which also does business as Blue Cross and Blue Shield of Illinois, Blue Cross Blue Shield of Texas, Blue Cross Blue Shield of Oklahoma and Blue Cross Blue Shield of New Mexico**,** hereby authorizes Compliance Research Services, LLC to represent us in the submission of the above-referenced forms and to negotiate with insurance departments for their approval.

Sincerely,

Health Care Service Corporation,
a Mutual Legal Reserve Company

Karen M. Atwood
Senior Vice President
National Accounts

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

Company Name: Health Care Service Corporation

Form Numbers: COC-CB-LG-0707 and ETGB-AR-HCSC-07

I hereby certify that to the best of my knowledge and belief, the above forms and submission comply with Arkansas Insurance Bulletin 9-85, in that the differential of benefits between PPO and non-PPO providers does not exceed 25%.

Scott Hilgeman
Vice President and Chief Underwriter

May 27, 2008
Date

SERFF Tracking Number:	*CMPL-125649032*	*State:*	*Arkansas*
Filing Company:	*Health Care Service Corporation*	*State Tracking Number:*	*39016*
Company Tracking Number:	*HCSC ET BCBSTX*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*HCSC ET BCBSTX*		
Project Name/Number:	*HCSC ET BCBSTX/HCSC ET BCBSTX*		

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Rider	05/15/2008	HCSC Arkansas ET Rider_rev080907.pdf

RIDER FOR RESIDENTS OF THE STATE OF ARKANSAS

If you reside permanently in the state of Arkansas, the [Certificate][Benefit Booklet] to which this Rider is attached and becomes a part is amended as stated below to conform to the requirements of the state of Arkansas. In the event of a conflict between the [Certificate][Benefit Booklet] and this Rider, the provisions resulting in greater [benefits][Benefits] will be in effect.

1. **Individual and Family Eligibility**

   The eligibility provision outlining a change in coverage from [individual coverage][Individual Coverage][Single Coverage] to [family coverage][Family Coverage] is changed as follows:

   If you apply for a change from [individual coverage][Individual Coverage][Single Coverage] to [family coverage][Family Coverage] within 90 days of the birth or within 60 days of the adoption or [placement for adoption][Placement for Adoption] of a [child][Child], your [family coverage][Family Coverage] will be effective from the date of the birth, adoption or [placement for adoption][Placement for Adoption].

   If you do not apply for [family coverage][Family Coverage] within 90 days of the birth or within 60 days of the adoption or [placement for adoption][Placement for Adoption] of a [child][Child], you can make application at any time. Your [dependents][Dependents] will be subject to the [preexisting condition waiting period][Preexisting Condition Waiting Period] outlined in the [Certificate][Benefit Booklet] to which this Rider is attached. The change will be effective on a date that has been mutually agreed to by your [Employer][Group] and [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma].

2. **Family Coverage**

   The eligibility provision concerning adding [dependents][Dependents] to [family coverage][Family Coverage] is changed as follows**:**

   If you apply to add your newborn [child][Child] to your [family coverage][Family Coverage] within 90 days of the [child's][Child's] birth or to add your adopted [child][Child] or [child][Child] placed for adoption to your [family coverage][Family Coverage] within 60 days of the adoption or [placement for adoption][Placement for Adoption], coverage for your [dependent][Dependent]will be effective from the date of the birth, adoption or [placement for adoption][Placement for Adoption].

   If you do not apply to add your newborn within 90 days of the birth, or your adopted [child][Child] within 60 days of the adoption or [placement for adoption][Placement for Adoption], you can make application at any time. Your [dependents][Dependents]will be subject to the [preexisting

condition waiting period][Preexisting Condition Waiting Period] outlined in the [Certificate][Benefit Booklet] to which this Rider is attached. The change will be effective on a date that has been mutually agreed to by your [Employer][Group] and [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma].

3. Providers

Benefits for the following Providers will be paid at the same level as other Providers.

- [Advanced practice nurses][Advanced Practice Nurses].
- Athletic trainers.
- [Audiologists][Licensed Audiologists].
- Certified orthotists.
- [Chiropractors][Doctors of Chiropractic].
- Community mental health centers or clinics.
- [Dentists][Doctors of Dentistry]
- [Coordinated Home Care][Home Health Care][home health care].
- Hospice care.
- Hospital–based service.
- Hospitals.
- Licensed ambulatory surgery centers.
- Licensed [social workers][Clinical Social Workers].
- Licensed [dieticians][Dieticians].
- Licensed [professional counselors][Professional Counselors].
- Licensed psychological examiners.
- Long–term care facilities
- [Occupational therapists][Licensed Occupational Therapists][Occupational Therapists].
- Optometrists.
- Pharmacists.
- [Physical therapists][Licensed Physical Therapists][Physical Therapists].
- Physicians and surgeons (M.D. and D.O.).

- [Podiatrists][Doctors of Podiatry].
- Prostheticists.
- [Psychologists][Doctors of Psychology].
- Respiratory therapists.
- Rural health clinics; and
- [Speech pathologists][Licensed Speech–Language Pathologists].

4. [Speech Therapy

The [speech therapy][Speech Therapy] benefit is revised to delete the [Benefit Period][benefit period] maximum.]

5. Well Child Care

Benefits will be provided for [Eligible Expenses][Eligible Charges][Covered Charges][Allowable Charge] rendered by a Physician to [children][Children] under age 19, even though they are not ill. Benefits will be limited to the following services:

- Immunizations;
- Routine diagnostic tests;
- 20 physical examinations at approximately the following age intervals:
    - Birth,
    - Two weeks,
    - Two months,
    - Four months,
    - Six months,
    - Nine months,
    - 12 months,
    - 15 months,
    - 18 months,
    - Two years,
    - Three years,
    - Four years,
    - Five years,
    - Six years,

- Eight years,
- 10 years,
- 12 years,
- 14 years,
- 16 years, and
- 18 years.

Benefits for immunizations will not be subject to any [copayment][Copayment], [deductible][Deductible], [coinsurance][Coinsurance] or [benefit period][Benefit Period] dollar maximum.

6. Phenylketonuria Treatment

Benefits will be provided for amino acid modified preparations, low protein modified food products and any other special dietary products and formulas prescribed by a Physician for the therapeutic treatment of phenylketonuria.

7. Musculoskeletal Disorders

Benefits will be provided for the surgical and non–surgical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head including [Temporomandibular Joint Dysfunction][temporomandibular joint disorder][Temporomandibular Joint Syndrome][temporomandibular joint dysfunction] and craniomandibular disorder. Your [benefits][Benefits] for musculoskeletal disorders are the same as your [benefits][Benefits] for any other condition.

8. Speech and Hearing

Benefits will be provided for the treatment of loss or impairment of speech or hearing by a speech pathologist or audiologist subject to the same limits, [deductibles][Deductibles] and [coinsurance][Coinsurance] as other [covered services][Covered Services].

9. In Vitro Fertilization

Benefits will be provided for in vitro fertilization procedures for you or your [dependent][Dependent] spouse when:

- Your or your spouse's oocytes are fertilized with the sperm of you or your spouse, and
- You or your spouse have a history of unexplained infertility of at least two years duration; or
- The infertility is associated with one or more of the following medical conditions:
    - Endometriosis;

- Exposure in utero to diethylstilbestrol, commonly known as DES;
- Blockage of or removal of one or both fallopian tubes that is not a result of voluntary sterilization; or
- Abnormal male factors contributing to the infertility.

- The in vitro fertilization procedures are performed at a [facility][Facility] licensed or certified by the Arkansas Department of Health which conforms to the standards of the American College of Obstetricians and Gynecologists', or are performed at a [facility][Facility] certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization.
- You or your spouse has been unable to obtain successful pregnancy through any less costly infertility treatment for which coverage is available under the [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan].

The [benefits][Benefits] for in vitro fertilization are the same as the [benefits][Benefits] provided under maternity benefit provisions. Cryopreservation, the procedure whereby embryos are frozen for late implantation, is included as an in vitro fertilization procedure.

10. Maternity Care

The coverage for [Maternity Services][Maternity Care][maternity care] is changed to allow [routine nursery care][Routine Nursery Care] and pediatric charges for a well newborn [child][Child] for up to five full days in a Hospital nursery or until the mother is discharged from the Hospital following the birth.

11. Cancer Treatment

Benefits will be provided for drugs used for the treatment of cancer if:

- The drug has been approved by the federal Food and Drug Administration for the treatment of the specific type of cancer for which it has been prescribed; and
- The drug is recognized for treatment of that specific type of cancer in one of the standard reference compendia or in the medical literature.

12. Mammograms

Benefits will be provided for mammograms as follows:

- A base line mammogram for a female who is at least thirty–five years of age but less than forty years of age;
- One mammogram every one to two years for a female who is from 40 to 49 years of age; and

- One mammogram a year for a female who is at least fifty years of age; or
- A mammogram upon recommendation of a woman's Physician, without regard to age, when the woman has had a prior history of breast cancer or when the woman's mother or sister has had a history of breast cancer.

13. Colorectal Cancer

Benefits will be provided for colorectal cancer examinations as follows:

- If you are more than 50 years of age;
- If you are age 50 and under and are at high risk for colorectal cancer according to the American Cancer Society colorectal cancer screening guidelines; or
- If you are experiencing bleeding from the rectum or blood in the stool, or if you have a change in bowel habits such as diarrhea, constipation or narrowing of the stool that lasts for more than five days.

14. Anesthesia and Dental Procedures

Benefits will be provided for anesthesia, [hospital][Hospital] or [ambulatory surgical facility][Ambulatory Surgical Facility] charges for dental procedures if it is certified that general anesthesia is required to safely perform the procedures and the patient is:

- A [child][Child] under seven years of age who is determined by two licensed [dentists][Dentists] to require without delay necessary dental treatment in a [hospital][Hospital] or [ambulatory surgical facility][Ambulatory Surgical Facility] for a significantly complex dental condition;
- A person with a diagnosed serious physical condition or [Mental Illness][Mental Health Care disorder][Mental Health Disorder]; or
- A person with a significant behavioral problem as determined by the [member's][Member's] Physician.

Immunizations are exempt from any [copayment][Copayment], [coinsurance][Coinsurance], deductible[Deductible] or dollar limit.

15. [Mental Illness][Mental Health Care][Mental Health] and [Substance Abuse Rehabilitation][Chemical Dependency][Drug Abuse and Alcoholism]

The benefit maximums for the [inpatient][Inpatient] and [outpatient][Outpatient] treatment of [Mental Illness][Mental Health Care][Mental Health Disorders] do not apply.

Your [benefits][Benefits] for [inpatient][Inpatient] and [outpatient][Outpatient] [Substance Abuse Rehabilitation][treatment of Chemical Dependency][treatment of drug abuse and alcoholism] are limited to a combined maximum of $6,000 each 24 month period. No more than $3,000 shall be provided in any 30 consecutive day period.

A combined lifetime maximum of $12,000 will apply to [benefits][Benefits] for [inpatient][Inpatient] and [outpatient][Outpatient] [Substance Abuse Rehabilitation][treatment of Chemical Dependency][treatment of drug abuse and alcoholism].

16. Late Claim Payments

The interest rate for a [claim][Claim] not paid on time by the claim administrator is 12%.

17. Continuation of Coverage

If you have been insured continuously under this [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan] for at least three months and your coverage has been terminated for any reason other than nonpayment of the required contribution, you may continue coverage under this [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan] for an additional three months. You must request continuation in writing no later than 10 days after the termination of employment or membership or a change in marital status. You must pay the entire premium including any portion paid by your former [employer][Employer]. Continuation of coverage is subject to the [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan] or a successor [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan] remaining in force.

Continuation of coverage shall end at the earliest of the following dates:

- 120 days after continuation of coverage begins;
- The end of the period for which the individual made a timely contribution;
- The contribution due date following the date the individual becomes eligible for Medicare; or
- The date on which the [policy][contract] is terminated or the [group][Group] withdraws from the [group health plan][Health Benefit Plan][Group Health Care Plan][Group Health Plan].

Except as amended by this Rider, all terms, conditions, limitations and exclusions of the [Certificate][Benefit Booklet] to which this Rider is attached will remain in full force and effect.

[Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)
(Blue Cross and Blue Shield of Texas)
(Blue Cross and Blue Shield of New Mexico)
(Blue Cross and Blue Shield of Oklahoma)

Raymond F. McCaskey
President

Thomas C. Lubben
Secretary]